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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 **PROPOSED FINDINGS AND LEGAL CONCLUSIONS 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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The California Department of Insurance ("Department" or "CDI") requests the following Findings of Fact and Legal Conclusions.

The sections of the Proposed Findings of Fact and Legal Conclusion correspond to the sections in CDI's Opening Brief.

PROPOSED FINDINGS OF FACT

I. INTRODUCTION

1. No findings of fact are being sought here relating to this section of CDI's Opening Brief.

II. BACKGROUND

A. Acquisition of PacifiCare by United

2. In 2005, PacifiCare Life and Health Insurance Company ("PLHIC") served approximately 148,000 members under a license issued by the California Insurance Commissioner. (RT 7316:3-6 (Berkel).) PLHIC was a subsidiary of PacifiCare Health Systems ("PHS"). (Exh. 5252, p. 6927; RT 7320:2-6 (Berkel).)

3. At the time, the company enjoyed a good reputation for providing excellent customer service (RT 2317:23-2318:2 (Norket); RT 8266:15-18 (Berkel)), and had no significant compliance issues prior to 2006. (RT 597:21-598:6 (Vandepas); RT 124:21-125:5 (Smith); RT 1208:17-21 (Black); Exh. 1184, p. 8.)

4. In July 2005, United Health Group ("UHG" or "United") announced its intention to acquire PHS. (Exh. 5265, p. 1941; RT 7320:2-6 (Berkel); RT 10593:20-22 (McFann).) The transaction, which was valued at roughly $8.2 billion (Exh. 625, p. 7042), required approval by the California Insurance Commissioner.

5. In November, 2005, the Commissioner conducted an investigatory hearing into the acquisition, at which several United and PacifiCare executives testified. (Exh. 625; RT 7937:19-7938:18 (Berkel).) The Commissioner expressed concerns about United's compliance history and was assured by United's representatives that United had put the problems behind it and would not repeat them with PacifiCare. (Exh. 625, pp. 7145-7149.)

6. At the hearing the executives represented that they would maintain PacifiCare's extensive operations in California and expand the insurance company's business in the state. Although the merged company would lay off approximately 200 California staff, according to PacifiCare executives, "the vast majority of our employees in California will remain with the company" and "the overall employee population for PacifiCare in California [would] remain relatively constant." (Exh. 625, pp. 7072, 7096-7097; Exh. 5265, p. 1939; RT 9018:17-25 (Monk).)

7. PacifiCare executives also touted the additional resources and technology that United would bring to benefit California consumers and providers. (Exh. 625, pp. 7075-7076.)

8. These representations were made with the expectation that the Commissioner would rely on them in deciding whether to approve the merger. (RT 8997:7-8998:8 (Monk).)

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

10. The commitments made to the Commissioner at the hearing were not kept. (Exh. 5265, p. 1939.)

B. The Immediate Push for Synergies

11. The Department contends that PacifiCare maintained a general business practice of hastily implementing cost-cutting measures without adequate understanding of the relevant systems and processes.

12. Even before the acquisition closed, the two companies committed to quickly integrating PacifiCare's operations into United's and established cost-cutting targets.

a. The two companies established an aggregate synergy goal of $100 million to be "achieved 6 to 9 months after closing." (Exh. 943, p. 8907.) "Synergies" include "revenue upside" as well as "cost reduction" in "FTEs (full-time equivalents), vendor contracting, platform synergies, wage rate savings,

infrastructure, etc." (Exh. 434, p. 3044.) This synergy projection was based on an "incomplete" due diligence process that did not include a "robust understanding" of integration costs. (Exh. 5265, p. 1941.)

b. Shortly after the December 21, 2005, closing, United told investors that it expected to achieve between $50 million and $75 million in synergies during the first year of the integration, net of any integration costs, and up to $350 million total synergies over the course of two to three years. (Exh. 5265, p. 1942; Exh. 457, p. 9242; Exh. 433, p. 621; RT 18395:20-24 (Wichmann).)

13. In late 2005, United and PacifiCare formed teams to plan and execute the integration. (RT 5350:8-19 (Labuhn); 5997:3-11 (Vonderhaar); RT 17647:23-17649:10 (Watson).)

14. Each of the teams was tasked with "establish[ing] synergies" "[b]ecause promises had been made to Wall Street." (RT 17652:13-17653:9; 17648:14-17 (Watson).) The "corporate initiative to drive down operating costs" imposed "internal operating income" ("IOI") benchmarks and synergy "commitments that each of the segments had to achieve." (Exh. 546, p. 8116; RT 15551:14-15552:12 (McMahon).)

C. Cypress Layoffs and Operation Closures

15. A "big part" of the integration teams' responsibilities was to "identify people to eliminate to meet our synergies." (RT 17652:17-23 (Watson).)

16. To that end, one of the main integration projects was closing several operations that had historically been performed at PacifiCare's Cypress office and transferring those functions to outside vendors or other United offices. (RT 17655:19-17656:8 (Watson).) The planning for these layoffs and closures began shortly after the acquisition closed. (RT 17657:12-17; 17675:13-21 (Watson); RT 3165:5-11 (Murray).)

a. United instructed the Group Services, Transactions, and Customer Care operational teams to "align" their staff to United's standardized staffing ratios, which increased the number of staff reporting to each manager and supervisor. (RT 17652:17-23; 17653:10-17655:1 (Watson); RT 6006:14-6008:6; 6285:10-

19 (Vonderhaar); Exh. 457, pp. 9243, 9274; see also Exh. 550, p. 6321 [each Claims manager went from supervising 35 staff to supervising 65]; RT 5394:12-17 (Labuhn); RT 17653:10-17655:1 (Watson); RT 6285:10-19 (Vonderhaar).)

b. This staffing ratio exercise was designed to achieve synergy targets (Exh. 805, p. 3760 [row 7]) and was one way the integration teams determined how many PacifiCare employees would be laid off. (RT 17657:18-17658:12 (Watson).)

17. The company soon announced its intent to close Claims and Customer Service operations in Cypress and transfer those functions to vendors and to other PacifiCare offices. It also announced its intent to close the Cypress Mail Room, Quality, and Training departments. (Exh. 283, p. 3656; RT 2498:15-24 (Sing); RT 5365:2-20 (Labuhn).)

18. Over the spring and summer of 2006, PacifiCare outsourced several key functions performed by the staff being laid off or by vendors under contracts with PacifiCare.

a. Sorting of paper mail, scanning and data-entry of paper claims, and scanning and routing of claim-related documents was outsourced to Lason, which performed the work in Utah and India, for an annual savings of $1.1 million. (Exh. 5443; Exh. 283, p. 3659; Exh. 517, p. 1847 [number 28]; RT 3602:13-15 (Murray).)

b. The company laid off all 22 Cypress-based PLHIC claims examiners (Exh. 283; Exh. 805, p. 3786; Exh. 5348, p. 8455; RT 6774:18-21 (Vonderhaar); RT 11333:13-19; 10280:21-23 (Berkel)) and transitioned the bulk of PPO claim processing, including some reworks, to a vendor called MedPlans. (Exh. 5348, p. 8455; Exh. 528, p. 2687; RT 6216:23-6217:8 (Vonderhaar); RT 3468:18-24 (Norket) [all but stop loss and transplant].)

c. The company transferred the telephone customer service function to West Corporation in Huntsville, Alabama and to PacifiCare's San Antonio office. (RT 2482:14-25 (Sing).)

d. The printing and mailing of checks, explanations of benefits ("EOBs"), and letters, which had been performed for PacifiCare by the IDC unit of IBM, was transferred to Duncan, a United subsidiary located in South Carolina, for annual savings of $3 million. (RT 4268:8-20; 4281:11-16; 4270:23-4271:1 (Oczkowski); Exh. 406.)

e. Other functions handled by IDC, including mail distribution, were transferred to Xerox. (RT 6879:10-17 (Vonderhaar).)

f. The company outsourced processing of eligibility forms to Accenture, resulting in the layoffs of 124 FTEs and savings of $4.4 million each year. (Exh. 514, p. 3617 [number 3]; Exh. 540, p. 3760.)

19. The layoffs were executed "for synergies and the integration process" (RT 17659:1-9 (Watson)) and, indeed, achieved synergies (RT 18118:19-18119:2 (Monk)).

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

20. The Department contends that the reduced staff was unable to successfully manage major changes in systems and procedures simultaneously implemented by PacifiCare.

21. Simultaneous with the push to achieve synergies during the first year after the acquisition, PacifiCare moved to implement many complicated operational changes.

22. By April 2007, 39% of the PacifiCare employees had terminated, by lay-off or voluntary departure. (Exh. 455.)

23. PacifiCare later acknowledged that the implementation of United's "standard staffing and management ratios" left the company "understaffed in several critical areas." (Exh. 753, p. 4220.)

24. In the summer of 2007, David Wichmann, the president and chief operating officer of UnitedHealthcare (RT 15856:14-17 (Wichmann)) told employees at PacifiCare's Cypress office that the company had "cut too deep" and apologized for laying off so many legacy PacifiCare employees. (RT 15341:7-15342:6 (Soliman); RT 9737:21-9738:9

(Berkel).) Materials prepared for his presentation to California regulators, including the Commissioner, called for Mr. Wichmann to "[a]pologize . . . for the poor transition" and the inadequate resources and lack of knowledgeable staff (Exh. 627, p. 0407) and to acknowledge that United had "underestimated how difficult it would be to integrate" the two companies (Exh. 5323, p. 2623).

E. Botched Transition of Critical Process to Outside Vendors

25. The Department contends that PacifiCare's transition of critical functions to outside vendors was inadequately planned, tested, documented, and monitored; was under-funded; was not prudently managed; and lacked the assignment and acceptance of responsibility and accountability for the performance of the vendors.

1. Outsourcing of Mail Routine, Claims Keying, Document Storage, and Preprocessing to Lason

26. Between May and October of 2006, PacifiCare transferred several "particularly critical" mail processing functions to Lason (RT 6316:22-24 (Vonderhaar)). These functions included:

a. sorting paper mail between "keyable" claims and "non-keyable" correspondence (RT 3188:22-3189:6 (Murray),

b. "keying" or data entry of paper claims into RIMS,

c. scanning and routing non-keyable correspondence,

d. and scanning secondary documents (correspondence that had been used to process a claim) for storage in PacifiCare's FileNet system. (Exh. 283, p. 3659; Exh. 5046, p. 2236; RT 3180:9-3181:25; 3201:22-3202:13; 14308:24-14309:14 (Murray).)

27. The company also outsourced some claim pre-processing functions to Lason, including manual member eligibility and provider matching. (Exh. 517, p. 1847; RT 3217:19-3218:6; 14290:21-24 (Murray); RT 14837:19-14838:5 (Vavra).)

a. **DocDNA**

28. In conjunction with the outsourcing to Lason, PacifiCare implementing a mail-routing system called DocDNA, which was to replace manual routing that PacifiCare had been using.

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

30. The PacifiCare mail room received a "very wide range of documents" so it was "a very complex process" to sort and route them properly. (RT 13682:12-15; 13699:23-25 (Murray); RT 13898:1-6 (Vavra).) Before the acquisition, this correspondence was sorted 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; 14314:15-16 (Murray).)

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

32. Beginning in July 2006, documents were shipped from PacifiCare's post office box to Lason's Salt Lake City Regional Mail Operation "RMO" where the correspondence was separated from keyable claims, scanned, and e-mailed to Lason's facilities in India. (Exh. 5443; Exh. 5446; RT 13700:19-13701:14 (Murray).)

33. To replace the institutional knowledge of the appropriate destination of each document possessed by the seasoned mail sorter and her supervisor, PacifiCare designated a

manager, Jonathan Murray, to work with Lason to customize DocDNA, Lason's proprietary document routing software. (RT 13679:20-13680:2; 13691:23-13692:13 (Murray).)

34. Mr. Murray's approach was to have Lason's India staff categorize each document according to one of 65 "document types," eight states, and four lines of business. (RT 13725:16-25 (Murray).) The categorization, or "doc typing" decision, directed each document to one of dozens of "queues" from which it was retrieved and processed by PacifiCare staff. (RT 3197:23-3198:6; 13701:6-13702:5 (Murray); Exh. 5445, p. 3776.) Some of those queues fed into the REVA system, by generating a prompt for a rework examiner who could then access DocDNA to review the document related to the rework request. (RT 3199:5-23 (Murray).)

35. To guide this categorization, Mr. Murray relied on a single document, a 300-page binder of exemplars for Lason staff to consult in selecting a document type. (Exh. 5444; RT 13749:1-6 (Murray).)

36. The document routing instructions were "fragmented and complex" (Exh. 373, p. 0560; Exh. 577) and required intensive scrutiny of each document combined with a high level of familiarity with American health systems.

37. Throughout 2006 and 2007, Lason staff expressed confusion about the doc typing rules, and Mr. Murray revised the binder repeatedly. (RT 13749:21-13750:16; 13715:9-25 (Murray); Exh. 373, p. 0560.)

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

39. PacifiCare witnesses have acknowledged that the DocDNA system implemented in July 2006 made it virtually impossible for Lason to properly route the mail. (RT 3207:15-17 (Murray); RT 6801:23-6802:14; 6317:18-20; 6805:4-12 (Vonderhaar).)

40. Eventually, in 2008, PacifiCare vastly simplified the doc-typing rules, which led to a much smaller and clearer decision tree and "made it significantly easier" to route documents correctly. (RT 3206:7-25; 14384:18-14385:8 (Murray).)

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

42. Even after documents arrived in the proper work queue, "there were buildups of inventory" in the queues because PacifiCare did not dedicate sufficient staff to process the documents with "a turnaround time that would keep documents moving." (RT 13784:1-25 (Murray).)

a. Thousands of documents languished in queues for 30 days or more. (Exh. 526, p. 2770; Exh. 666, p. 1103.)

b. A "huge cleanup effort" of two queues in July 2007 revealed "files going back to 2006." (Exh. 277.)

c. The inventory of aged documents sitting in DocDNA remained high throughout 2007. (Exh. 526, p. 2770; Exh. 666, p. 1103; Exh. 370, p. 8617.)

d. A year after its implementation, Senior Vice President Susan Berkel characterized claim-dependent correspondence routing as "broken." (Exh. 5265, p. 1939.)

b. **Processing of Paper Claims**

43. At the time of the acquisition, PacifiCare's Cypress mail room was the entry point for paper claims, which comprised almost half of PLHIC's claims. (RT 7419:17-24 (Berkel); RT 3189:25-3190:10 (Murray).) These claims were sorted and scanned by the RMO and routed to Mexico for entry into the appropriate claims engine — RIMS for PPO and POS claims, and NICE or ILIAD for HMO claims. (Exh. 5446.)

44. Before entering RIMS, PPO claims were to go through several preliminary processing steps in Claims Exchange, RIMS' "front end," including eligibility matching (to ascertain whether the member was covered by that insurance product on that date of service, and whether the service was covered by the policy) and provider matching (to link the provider listed on the claim to a provider name, tax identification number, and address in the claim platform). (Exh. 5223; RT 7407:21-7409:24 (Berkel).) If Claims Exchange did not automatically match the claim to an eligible member, covered service, and provider, the claim fell into a "matching queue," and a human had to research and resolve the matching issue before the claim could be uploaded to RIMS. (RT 7408:10-7409:22 (Berkel); Exh. 5223.)

45. In May 2006 PacifiCare transferred to Lason the function of entering data from paper claims into RIMS (Exh. 5446; Exh. 5046, p. 2236), and in October 2006 the company outsourced the work of researching claims that had fallen into Claims Exchange work queues. (Exh. 512, p. 1282; Exh. 365, p. 6870.) PacifiCare failed, however, to give Lason the means to determine whether claims should be keyed into RIMS, NICE, or ILIAD.

46. Prior to outsourcing, the Cypress mail room staff succeeded in routing claims to the proper platform by looking up members in the claims engines when eligibility was unclear. Lason's RMO staff did not have access to the claims platforms, and their default instruction was to route claims to NICE. (Exh. 573, p. 2770; Exh. 711; RT 14315:6-19 (Murray).) PPO claims "rejected" from NICE because the system could not match the claim to an eligible HMO member. (RT 6117:14-22; 6352:3-9 (Vonderhaar).)

47. PacifiCare also failed to give Lason proper instructions for separating keyable claims from nonkeyable documents or correct keying guidelines. (Exh. 885.)

48. Throughout the multi-year implementation, PacifiCare belatedly discovered instances of claim-related documents being filed in queues to which nobody was attending, stranding the documents and preventing timely processing of claims. For example, in late 2006, PacifiCare discovered that Lason had not been "working" several Claims Exchange queues. According to Lason, PacifiCare had failed to provide sufficient access to Claims Exchange and instructions for processing the claims. (Exh. 572.)

49. As a result of these breakdowns, an "inordinate amount" of paper claims were "rejected" from PacifiCare claims systems and could not be adjudicated. (Exh. 410, p. 7401; Exh. 339; Exh. 885.)

a. Through the summer and fall of 2006, the rejected hard copy claims had to be mailed back to PacifiCare offices for research and then returned to Lason for a second attempt at data entry. (Exh. 410, p. 7401; Exh. 896.)

b. Many claims were several weeks old by the time they were corrected and returned to Lason. (Exh. 339, p. 2462; Exh. 366, p. 7266.)

50. PacifiCare addressed the "reject" problem in October 2006 by instructing Lason staff to enter "dummy" values in necessary claim fields "to force the claims into the system." (Exh. 885, p. 4881.) This merely shifted the locus of the problem: once forced into Claims Exchange, the formerly rejected claims would "error out" to a work queue for manual research. (Exh. 885, p. 4881; RT 17456:20-17457:8 (Vavra); RT 14296:9-16 (Murray).)

51. Because Lason had no way to "look up individual members and determine into which PHS platform the claims should be keyed" (Exh. 573), claims that had been errored out from one platform would be sent to another platform.

a. Claims sometimes "bounced" or "looped" between platforms up to eight or nine times before being adjudicated. (RT 13958:1-13959:5 (Vavra); Exh. 881.) This "looping" remained a "very big issue" throughout 2007. (Exh. 881.)

b. In late 2007, "a huge 62%" of paper claims were erroring out of the autoadjudication process because of "match issues," including approximately one-third of paper claims that failed to match with an eligible member. (Exh. 554.) In December 2007, noting that this problem was causing PacifiCare to "fail the prompt pay laws of California," Ms. Berkel urged that it was "imperative to come up with a solution." (Exh. 554, p. 0310.)

52. The proposed solution, FETrain, was already in place at RMOs serving other United subsidiaries but was not timely implemented for PacifiCare.

a. FETrain allowed users to perform an eligibility search across all United and PacifiCare platforms, and testing showed that it would have significantly improved eligibility matching for PacifiCare claims. (Exh. 573, p. 2770.)

b. The proposal met "resistance" from PacifiCare's finance department, despite the fact that, at roughly $65,000, the project was "relatively low cost and high value." (Exh. 554, p. 0310.)

c. FETrain was not implemented until "late 2008, early 2009." (RT 6118:7-11 (Vonderhaar); Exh. 711.)

c. **Storage of Secondary Documents**

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

54. The task of scanning and logging these documents into FileNet, PacifiCare's long-term storage system, was outsourced to Lason's operations in Mexico. (Exh. 365, p. 6872; RT 3690:25-3691:3 (Murray).)

55. Because of weaknesses in the process, Lason was not entering member and claim numbers on the image, preventing PacifiCare staff from systematically retrieving the

documents when needed. (Exh. 575, p. 4004; Exh. 365, p. 6872; RT 14901:25-14902:17; 14908:25-14910:15 (Vavra).)

56. Because there was no oversight of this process (Exh. 365, p. 6872), PacifiCare did not realize until August 2007, a full year after outsourcing this function, that secondary documents were "in a black hole."

a. Lason was not indexing all documents. (Exh. 342, p. 8514.)

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

57. After this discovery, PacifiCare assigned "ownership" of the secondary document function to Kelly Vavra's Data Capture team (Exh. 365, p. 6872) and created a common cover sheet to be used throughout the company when sending secondary documents to Lason that would "ensure they were being indexed appropriately in Imaging." (Exh. 355, p. 8503.) However, even that measure had not yet been implemented six months later (Exh. 355, p. 8503), nor had the lost secondary documents been indexed (Exh. 365, p. 6873; Exh. 376, p. 8233).

58. In March 2008, PacifiCare staff remained confused about who was responsible for overseeing Lason's indexing and use of the new cover-sheet convention. (Exh. 1031; RT 17432:7-17433:12 (Vavra).)

d. **Routing of Mail**

59. After Xerox took over, mail was "just dumped in a room." (Exh. 401, p. 4853 [Aug. 1, 2006, 8:13 p.m., Switzer e-mail].)

60. Ruth Watson testified that when her unit suddenly stopped receiving premium checks because the mail was no longer being delivered, had a manager load her pickup truck with the mail for the entire building and then had three people work full time for three days sorting through the mail, in which they identified $5 million in premium checks and delivered the mail for the rest of the building. (RT 17704:22-17705:2.)

61. The mail room transition contributed to mail routing issues that lasted into Spring 2007. (Exh. 5258, p. 7105 [See "Claims Integration Issues"]; Exh. 410, p. 7401 [number 6].)

e. **PacifiCare's Overall Mismanagement of the Lason Outsourcing**

62. The Department contends that the poor performance of the Lason document routing, secondary document indexing, claims data entry, and preprocessing functions caused or contributed to PacifiCare's failure to timely pay claims and respond to provider disputes and to PacifiCare's practices of wrongly denying claims and requesting information claimants had already submitted. (Exh. 116, p. 1298; Exh. 882, p. 7641; RT 8474:11-17 (Berkel); Exh. 342, p. 8514; Exh. 666, pp. 1103-1104.)

Relentless Pursuit of Synergies Forced an Unrealistic, Inflexible Implementation Schedule

63. A rushed implementation of DocDNA led to inflexible, unrealistic timelines for a major operational change.

a. Compared to PacifiCare's measured 2004 implementation of the REVA system for managing reworks, in which it phased the system in slowly, achieving stability with HMO reworks before expanding to PPO (RT 3199:5-11; RT 13670:20-13671:5 (Murray)), and in contrast to PacifiCare's cautious pre-acquisition plans for automating mail routing (RT 3655:6-13; RT 13670:20-13671:5 (Murray)), the Lason transition was neither cautious nor well-planned.

b. Two months after the United takeover, in February 2006, Lason was selected as the vendor and PacifiCare-wide implementation of DocDNA was targeted for July 1, 2006. (Exh. 5446.)

c. Because the synergy targets were predicated on expectations of when the work would be transferred (Exh. 517, p. 1848), the timeline was "not negotiable." (Exh. 678, p. 2846.)

64. The implementation schedule did not provide sufficient time for planning, testing, and training and proved unrealistic.

a. Mr. Murray began to work on DocDNA "in earnest" in March 2006. (RT 13695:19 (Murray).) He testified it was "a challenge" to design and test DocDNA in that time, as he "didn't have a lot of time to spare" and "couldn't think about it for a long period." (RT 13695:4-15 (Murray).)

b. The company ignored protests from PacifiCare staff that "it was a pretty fast transition for the kind of work that we were moving forward." (RT 6326:1-7 (Vonderhaar).)

c. Mr. Murray predicted that Lason would not be able to deliver a completed routing system by July 2006, as the process was "not yet at a conceptual design phase" in April 2006. (Exh. 889, p. 7286.)

65. ,Lason's concerns that it would be unable to provide a fully functional document routing system by July were not heeded.

a. Lason asked PacifiCare to keep the work internal until staff could be trained or to send a trainer to India. (Exh. 377, p. 7283; 3659: 20-3660:16 (Murray).) PacifiCare refused both to postpone the layoffs of Cypress mail room staff and to send a trainer to assist Lason in India. (RT 3656:25-3657:5; 3659:11-14 (Murray); RT 14052:10-18 (Vavra).)

b. Although PacifiCare recognized that "Lason's team [was] too inexperienced to accurately route hard copies" and that distributing mail-routing work to remaining PacifiCare staff "would likely result in more accurate distribution in the short term," PacifiCare insisted that Lason "find a way to get [its staff] trained on document recognition and distribution" so that Lason could take over mail routing by July 1. (Exh. 377, p. 7282-7283; RT 3661:21-3662:12 (Murray).)

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

66. It should have been apparent from the beginning that asking Lason staff to leaf through an enormous binder of paper exemplars could not have resulted in accurate routing of the "very wide range of documents" PacifiCare received each week. (RT 13682:12-15; 13699:23-25 (Murray).)

67. The DocDNA transition also represents a failure to thoroughly review existing processes or conduct "detailed business and system analysis" before eliminating staff and outsourcing business functions. (Exh. 466, p. 0888; Exh. 448, p. 8705; RT 8497:19-8498:7 [Berkel].)

a. Due to the abbreviated implementation schedule, the company did not adequately analyze and document the pre-outsourcing mail routing process (RT 6328:19-6329:3 (Vonderhaar)) or fully evaluate the proposed DocDNA system (Exh. 5258, p. 7105.)

b. Before implementation of DocDNA, PacifiCare conducted "a couple rounds" of testing, with 70 or 80 documents in each round. (RT 13772:8-13773:4 (Murray).) In light of the complexity of document routing and the wide variety of documents received via mail, the testing conducted for DocDNA before implementation was inadequate.

68. Before PacifiCare implemented DocDNA, other vendors warned of the risks inherent in overly complex mail routing processes: "[A]ny deviation to the address on the mail piece is an opportunity for error. If the instructions are not clear, or they vary based on the type of mail piece, the risk increases." (Exh. 596, p. 7918.) ACS, PHS' chosen vendor, had balked at designing a system with 65 document types, informing PacifiCare that most routing systems had only five or six types. (RT 13767:2-13769:9 (Murray).).

69. Although PacifiCare had anticipated that some documents would be misrouted, it designed DocDNA with "no method of systematically locating a document within a DocDNA queue." (Exh. 574; Exh. 709; RT 13712:4-8 (Murray).) As a result of this "ridiculous" "integration mistake" (Exh. 709), documents could only be found by

searching for a unique document identifier number "DCN" to which claims examiners and customer service staff did not have access. (RT 3275:2-17; 3620:25-3621:7 (Murray).)

70. In late 2007, Ms. Berkel sought approval for adding the ability to search DocDNA by member number but was told that the $40,000 expense "isn't in the budget." (Exh. 709; Exh. 632, p. 9282.) Her contemporaneous assessment that this response demonstrated how the obsession with synergies "drives irrational answers" (Exh. 632, p. 9282) is sustained on this record.

Lason Exemplifies PacifiCare's Lack of Proper Management of Vendors

71. The Department contends that a principal reason for Lason's poor performance and why it was not promptly identified and corrected was PacifiCare's failure to appropriately manage the functions it had outsourced. (RT 6317:18-20 (Vonderhaar) [PacifiCare "didn't give [Lason] the best direction"];RT 6805:4-12 (Vonderhaar) ["we designed something so complicated it was difficult to manage"]; RT 17469:17-17470:7 (Vavra) [claim rejection was a result of PacifiCare giving Lason inaccurate instructions].)

72. On several occasions, PacifiCare failed to give Lason instructions for handling the work it had assigned or gave inaccurate instructions, resulting in serious operational problems. (Exh. 577; Exh. 365, p. 6872; Exh. 885; Exh. 572.)

73. No one at PacifiCare had overall responsibility for the functions outsourced to Lason. (Exh. 5255; Exh. 911, Exh. 711; RT 14885:8-16 (Vavra).)

a. In late 2007, Ms. Berkel began calling for a "single point of contact for Lason/DocDNA." (Exh. 705, p. 1679.) She was informed that Kelly Vavra, a United Operations Director, was the "single owner over the Lason relationship" and "should be driving the controls and remediation efforts." (Exh. 706 [Auerbach 4:53 p.m.].)

b. According to Kelly Vavra, however, she was merely the "relationship owner" for Lason. She was not the "single point of contact," nor did she "own" the contract under which Lason's work was performed. (RT 14872:25-14873:14; 14839:9-20; 14864:5-8.)

c. Ms. Vavra knew very little about the correspondence routing work Lason performed. (RT 14892:4-25; 14894:22-14895:11 (Vavra).)

d. This "silo mentality" (Exh. 678, p. 2833; Exh. 288, p. 5466; RT 8486:18-8487:6 (Berkel)) delayed effective issue identification and remediation of operational defects.

e. The silos and lack of a single overall owner were responsible for secondary document indexing operating without any supervision by PacifiCare for over a year. (Exh. 365, p. 6872.)

74. The dispersed distribution of responsibilities led to confusion among PacifiCare managers about "who had oversight for what component." (RT 14865:4-15 (Vavra).)

75. Many serious operational deficiencies can be traced to the "gap[s]" in "the Lason oversight process." (Exh. 706 [Auerbach 4:53 p.m.].)

76. PacifiCare has admitted that its relationship with Lason exemplified the "partner management breakdowns" that plagued PacifiCare after its acquisition by United. (Exh. 662, p. 3221.)

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

77. The Department contends that Lason exemplifies the recurring PacifiCare practice of ignoring queues and orphaning business processes.

78. The individual queues and overall inventory of DocDNA were, by PacifiCare's admission, "poorly managed." (Exh. 342, p. 8514.)

a. PacifiCare did not ensure that there was an "owner" responsible for working each queue until the company was required to do so by regulators, a year after outsourcing the work. (RT 7466:11-23 (Berkel); Exh. 365, p. 6877; Exh. 601, p. 9158; Exh. 118, p. 3418; Exh. 606, p. 1820.)

b. Until May 2008, no one had centralized responsibility for monitoring DocDNA inventory or exercised overall responsibility for the document

routing function. (RT 3613:14-23 (Murray); RT 13988:5-11; 14879:6-17 (Vavra).)

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

a. As soon as DocDNA went live, documents began getting "locked" in DocDNA queues instead of being transmitted to REVA, so claims were not reprocessed and provider disputes were not responded to, in some cases for many months. (Exh. 341, p. 3979; RT 3273:7-19; RT 3286:9-13; RT 3288:16-22; RT 3292:19-3293:3 (Murray).)

b. The company did not discover the problem until January 2007 because it had no reconciliation report to ensure that the number of documents deposited in the REVA-designated DocDNA queues matched the number uploaded to REVA each day. (RT 3286:18-3287:2; RT 3289:3-5; RT 3292:2-4 (Murray).)

80. The reconciliation report created after the problems were identified should have been "in place from the beginning." (RT 3286:18-25 (Murray).)

81. After the REVA "locking" experience, PacifiCare should have promptly imposed reconciliation controls for each step of the document routing process. In late 2007, however, there were still "issues with not being aware of volume of REVA files coming from Lason" (Exh. 594, p. 4022 [number 1A].) and significant "reconciliation gaps" between the RMO, DocDNA, REVA, and FileNet. (Exh. 365, p. 6878; RT 14328:17-20 (Murray).)

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

83. PacifiCare delayed establishing quality, reporting, and reconciliation measures for DocDNA long after the unreliability of the document routing system was known to be affecting claims payment.

a. The company repeatedly noted in late 2007 that reporting around Lason's activities was "not adequate" and that the company needed "additional resources" for quality audits and reports. (Exh. 370, p. 8617; Exh. 365, p. 6879.)

b. Yet in April 2008, reporting and quality assurance for DocDNA remained "minimal" and "ad hoc." (Exh. 226, p. 7651; RT 14330:9-11 (Murray).)

84. The evidence shows that PacifiCare failed to allocate and identify responsibility for overseeing the DocDNA process, which resulted in documents being unattended, sometimes for significant periods, contributing to delays in proper processing of claims and provider disputes.

85. The evidence shows that PacifiCare failed to have in place the necessary audit trails and reconciliation reports to detect when documents became locked in queues, contributing to delays in proper processing of claims and provider disputes.

PacifiCare Persistently Failed to Hold Lason Accountable for Its Performance

86. The Department contends that PacifiCare failed to ensure that its vendor contract with Lason contained effective guarantees of satisfactory performance and failed to enforce what guarantees were belatedly adopted.

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

88. The SLAs were inadequate.

a. The standards only governed the accuracy of sorting between nonkeyable correspondence and keyable claims, and the speed by which the documents were forwarded from the RMO to Lason's offshore offices. (Exh. 336, pp. 5256, 5258; RT 13904:15-24; RT 13967:24-13968:6 (Vavra).) Once the mail arrived in Mexico or India, there were no applicable performance standards.

b. There were no SLAs governing the timeliness or accuracy of correspondence routing (Exh. 336; RT 13936:25-13937:7; 14848:8-12), keying of PLHIC claims (RT 13937:8-12; RT 14841:14-22; RT 14847:22-14848:7 (Vavra)), or indexing of secondary documents (RT 14915:7-10 (Vavra)).

c. Dirk McMahon, the chief operating officer of United Healthcare (RT 15482:7-15483:4 (McMahon)), agreed this omission was troubling. (RT 17573:5-14.)

89. Consequently, despite Lason's unsatisfactory performance in 2006, 2007, and the first half of 2008, it was assessed no penalties for failing to meet standards in that time. (RT 3673:12-3674:7 (Murray); RT 13986:1-20 (Vavra).) Nor was Lason audited or held to any standards, whether by monetary penalties or otherwise, for the crucial functions it performed. (Exh. 707, p. 9970 [Akaloshi 5:23 p.m. (number 25)] [Lason not held to PacifiCare standards for claims keying]; Exh. 370, p. 8617 [no metrics for Claims Exchange]; Exh. 1030 [auditing of doc-typing work began in January 2008]; RT 9813:22-9814:6 (Berkel); RT 17416:15-25 (Vavra); RT14330:12-20 (Murray) [no regular sampling of nonkeyable correspondence function].)

90. The inadequacies of the SLAs were not promptly remedied.

a. In September 2007, over a year after Lason had taken over the critical Cypress functions, Mr. McMahon demanded that Lason "be absolutely micro-managed into the ground" and observed that, if Lason was "going along fat, dumb and happy not paying out on service guarantees with their performance," PacifiCare needed to "re-jigger" the SLAs as soon as possible. (Exh. 575, p. 4003 [McMahon 8:49 a.m.].)

b. Six months later, PacifiCare renegotiated their SLAs with Lason. (Exh. 5458.) This agreement required the company to route 96% of mail within 72 hours of receipt and all mail within 96 hours. (Exh. 5458, p. 2732; RT 17387:3-22 (Vavra).)

91. The new SLA was not enforced.

a. Lason did not meet the turnaround time standard in May, June, July, or August of 2008. (Exh. 369, pp. 9186, 9187.)

b. Lason was subject to a penalty for those months (RT 17389:12-18 (Vavra)), but PacifiCare did not impose one. (RT 17437:4-11 (Vavra); Exh. 1028, p. 2.)

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

92. The Department contends that PacifiCare failed to act promptly to remedy the Lason deficiencies.

93. Problems with Lason's performance arose as soon as the outsourcing took effect. (Exh. 339; Exh. 340; Exh. 366; Exh. 571, p. 2532; RT 6317:5-6318:21 (Vonderhaar).)

a. Throughout 2006 and into 2007, PacifiCare's management complained about continued "issues" with Lason and "unacceptable" delays in correspondence routing, reciting the obvious: that the problems "wouldn't be happening if we hadn't outsourced" the work. (Exh. 572, p. 5064 [Vonderhaar 4:23 p.m.].)

b. In late 2006, PacifiCare knew that it was having problems routing and storing COCCs it received from members, as well as medical records and other documents received from providers. (Exh. 5009; Exh. 884, p. 5066 [Nakashoji 3:52 p.m.].)

c. Nine months later, the company again observed "a significant issue of missing documents" and noted that PacifiCare's own Network Management and Transactions departments had reported mailing documents to the RMO multiple times "and the documents don't show up indexed to claims." (Exh. 577.)

d. By mid-2007, PacifiCare knew that the problems with DocDNA were serious and intractable. (Exh. 5265, p. 1939 [July 2007: Berkel calls correspondence routing "broken"]; Exh. 361 [July 2007: Failure to timely process reworks attributed to Lason delays]; Exh. 526, p. 2771 [August 2007: "Issues again with aging in Lason queues."]; Exh. 575, p. 4003 ["Everytime we turn around there are issues with Lason and DocDNA."].)

94. PacifiCare did not implement meaningful remedial measures until 2008.

a. PacifiCare promised DMHC that it would review and update its policies related to mail intake and DocDNA by November 30, 2007 (Exh. 5290, Exh. D, pp. 21, 24) and told CDI it would "completely update" its DocDNA policies by the end of 2007. (Exh. 161, p. 13) Yet in Feburary 2008, the company's corrective action plan for Lason was only 50% complete. (Exh. 376, p. 8233.)

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

c. The relatively low-cost project of modifying FETrain to halt the claims-looping issue that was resulting in late-paid claims was implemented a year after the fix was proposed. (Exh. 554; RT 6118:7-11 (Vonderhaar); Exh. 711; Exh. 881.)

95. PacifiCare was aware that Lason was contributing to violations of law. (Exh. 882, p. 7641; Exh. 750, p. 7699; Exh. 554.) But the company favored one-time fixes and "workarounds" rather than analyzing and attacking the root causes (RT 6801:23-6802:14 (Vonderhaar)) and did not dedicate sufficient resources to analyze and remediate a process that it considered "broken" (Exh. 5265, p. 1939).

96. The evidence shows that in the three years following closure of the acquisition, PacifiCare maintained a general business practice of hastily implementing cost-cutting measures without adequate understanding of the relevant systems and processes.

97. The evidence shows that PacifiCare's practice of reducing staff at the same time it was implementing major changes in systems and procedures left PacifiCare unable to successfully manage those major changes.

98. The evidence shows that a principal reason for Lason's poor performance and why it was not promptly identified and corrected was PacifiCare's failure to appropriately manage functions it was outsourcing.

99. The evidence shows that PacifiCare's vendor-contracting practices were, in the case of Lason, inadequate to ensure that the contract would contain effective guarantees of satisfactory performance and inadequate in enforcing what performance guarantees were contained in the contract.

100. The evidence shows that PacifiCare's practice, in the three years following the acquisition, was to transition critical functions to outside vendors without adequate planning, testing, documentation, and monitoring.

101. The evidence shows that PacifiCare's practice was to under-fund the outsourcing of claims-related business processes.

102. The evidence shows that PacifiCare lacked a practice of prudently managing outsourced functions and the contractors to whom the functions were outsourced.

103. The evidence shows that in the three years following the acquisition PacifiCare's business practice was not to act promptly to remedy vendor deficiencies such as those encountered in the outsourcing to Lason.

104. The evidence shows that the deficiencies in PacifiCare's management of the Lason outsourcing caused delays and errors in processing PLHIC claims.

2. Outsourcing of Claims Processing to MedPlans

105. Beginning in 2004, PacifiCare used a vendor called MedPlans (later acquired by First Source) to add back-up claim processing capacity when claim volumes rose. (RT 6193:19-6194:10; 6216:15-22 (Vonderhaar).)

106. The Department contends that PacifiCare mismanaged this vendor relationship, leading to the misprocessing of PLHIC claims.

107. From the beginning of its relationship with MedPlans, PacifiCare was dissatisfied with the quality of the vendor's work. (Exh. 560, p. 4878.) Nevertheless, shortly after the acquisition, PacifiCare decided to lay off its Cypress claims staff in order to "migrate claim processing from higher cost offices to lower cost vendors," specifically MedPlans. (Exh. 550, p. 6321 [number 54]; RT 6188:16-24; 6197:4-8 (Vonderhaar).)

108. PacifiCare transferred the bulk of its PPO claims processing, including some rework, to MedPlans (Exh. 5348, p. 8455; Exh. 528, p. 2687; RT 6216:23-6217:8 (Vonderhaar); RT3468:18-24 (Norket)), and oversight of PPO claims processing was transferred to PacifiCare's San Antonio office. (Exh. 5046, p. 2236; Exh. 560; Exh. 5348, p. 8455.)

109. After the acquisition, supervision of MedPlans was transferred to United's Vendor Management staff, who "didn't really understand the PacifiCare legacy business," which undermined management of MedPlans performance with respect to PLHIC claims. (RT 6197:9-6198:10 (Vonderhaar); Exh. 558.)

a. PacifiCare initially believed its reliance on MedPlans would be short lived in light of the anticipated platform migration that would allow it to sunset RIMS. (Exh. 560, p. 4878.)

b. By September 2006, the company had abandoned those migration plans and was facing several more years on RIMS. (Exh. 5399.)

c. Yet, although PacifiCare's concerns with the quality of MedPlans adjudication decisions quickly escalated after September (Exh. 558; RT 6200:4-11 (Vonderhaar)), the insurer did not revisit its dependency on MedPlans, whose performance was unsatisfactory and "really a cause for termination." (Exh. 1032.)

110. In September 2007, PacifiCare was "frustrated" with MedPlans because the "same conversations [about quality] have been had over the past two or three years" and threatened that "if fixes are not made, [PacifiCare would] have to bring [the work] back in house." (Exh. 560, p. 4878; RT 6225:1-18 (Vonderhaar).) But the threat was hollow:

PacifiCare simultaneously told MedPlans that it regarded itself as "absolutely dependent on MedPlans for all the work" and felt it "ha[d] to work with them" despite grave concerns about the quality of MedPlans' performance. (Exh. 560, p. 4878; RT 6223:14-6224:3 (Vonderhaar).)

111. PacifiCare suspected that one threat to the integrity of MedPlans claims processing was its policy of paying its staff "piece rate" — based on the number of claims they processed. (Exh. 560, pp. 4878-4879; RT 6227:15-6228:7 (Vonderhaar).) But PacifiCare never secured a change in MedPlans' piece-rate formula. (RT 6233:25-6234:3 (Vonderhaar).)

112. PacifiCare's dealings with MedPlans is evidence of a practice of failing to properly manage vendor relationships to ensure statutory compliance.

3. Outsourcing of Eligibility to Accenture

113. PacifiCare announced a pilot program to transfer PacifiCare paper eligibility data entry functions to Accenture in the Philippines in March 2006 and completed the outsourcing in May. (Exh. 283, pp. 3656, 3658; Exh. 540; RT 17672:19-17673:5 (Watson); RT 5365:21-5366:5 (Labuhn).)

114. The Department contends that PacifiCare mismanaged this vendor relationship, reflecting a general policy of inadequately planning and testing outsourcing, inadequately remediating the problems that occurred, and of pursuing cost-savings in spite of clear evidence of deterioration in service and compliance. The Department also contends that the company's decisions with respect to the Accenture outsourcing reflect a lack of concern for members' interests, including their health, and a lack of good faith.

115. PacifiCare had "a lot of special processes" set up for certain employer groups (Exh. 541, p. 3728 [Madden 5:07 p.m.]), but the transition plan did not include retaining any Cypress-based eligibility staff to troubleshoot after the work was outsourced. (Exh. 542; RT 17683:7-17684:24 (Watson); Exh. 1093, p. 23:24-27.)

116. Ms. Watson told Mr. Labuhn, who headed the integration team over Group Services, that eliminating the entire eligibility team at once was too risky. (RT 17700:1-14

(Watson).) He dismissed her concerns, explaining "that there would be some bumps in the road, but 'we'd work through them'" to arrive at a "more efficient" process. (RT 17700:14-20.)

117. There were "countless" problems with the enrollment process following the outsourcing to Accenture. (Exh. 544, p. 6724; RT 17684:3-10 (Watson).)

118. The transition to Accenture involved a wholesale change in PacifiCare's processing of eligibility information, implemented without informing employer groups. Those changes unduly disadvantaged PacifiCare's members and employer groups. In some cases, the changes placed members' healthcare in jeopardy.

a. Before the acquisition, PacifiCare's enrollment staff was available to employer groups to resolve any errors they detected on eligibility forms. (RT 17679:13-17680:13 (Watson). PacifiCare decided to abandon this "high touch" practice when it outsourced the work to Accenture; the company simply mailed back without entering the member's data any form that contained an error. (RT 18432:20-18433:18 (Wichmann); RT 17685:9-16 (Watson); Exh. 542.)

b. It took approximately two weeks for the returned forms to reach employers after being mailed from the Philippines. In the meantime, the members were deemed ineligible and denied care. (RT 17681:21-17682:23 (Watson).)

c. PacifiCare did not inform employer groups that Accenture would not perform the outreach to fill gaps in enrollment forms that PacifiCare had done prior to the acquisition. (Exh. 1093, p. 23:15-21.) As a result, 40% of eligibility forms were rejected by Accenture, leading providers to turn away new members, some of whom remained unenrolled for up to two months. (Exh. 542, p. 4911; Exh. 1065; Exh. 678, pp. 2784, 2829, 2857, 2879, 3016; RT 10417:19-10419:15 (Berkel).)

d. Ms. Watson referred to the transition to Accenture as "one of the most difficult service breakdowns I've ever experienced" in a 30-year career. (RT 17683:25-17684:14.) Other executives agreed that the organization failed in

its execution of this transition and that the process to "escalate" the resulting problems for members was "extremely weak." (Exh. 1064 [Frey 10:56 a.m.]; RT 18420:4-14 (Wichmann) [confirming that Exh. 1064 refers to enrollment]; Exh. 5265, p. 1945 ["deteriorating . . . service around eligibility issues" after the eligibility function was removed from Cypress].)

119. The evidence shows that the transition of eligibility data entry to Accenture was hastily implemented, inadequately planned and tested, and poorly executed. These deficiencies can reasonably be inferred to have caused delayed or denied medical care and incorrect and delayed processing of claims.

120. PacifiCare's laying off the entire Cypress enrollment staff without adequate notice to members and employers, without retaining any trouble-shooting capability, and without providing for timely resolution of problems reflects a lack of proper concern for members and employers and constitutes a general business practice of placing cost-cutting ahead of the reasonable needs of members. It also evinces a lack of good faith in its efforts to discharge its obligations to members and groups.

4. Outsourcing of Customer Care to West

121. The Department contends that following the acquisition PacifiCare pursued practices with respect to its customer service function was sharply degraded to cut costs.

122. After the acquisition by United, PacifiCare's customer service representatives were pressed to minimize call time, creating incentives for Customer Service Representatives ("CSRs") to terminate calls even if the caller's concern was left unresolved. (Exh. 352; RT 3392:3-3393:5 (Sing); RT 13558:8-11 (Murphy); Exh. 678, pp. 2819, 2775, 2784, 2786, 2807, 2811, 2815, 2817, 2849, 2859, 2957, 2964, 2968, 2987, 2988, 3052, 3053, 3088, 3126, 3152, 3158, 3164, 3167, 3169, 3158, 3173.)

123. The company did not provide customer serve staff with adequate tools or training to furnish responses to callers' concerns.

124. Because CSRs were not properly trained to route callers to staff qualified to respond to their concerns, promises of call backs and corrections were not followed up on."

(Exh. 678, p. 2771; Exh. 289, p. 6599; Exh. 627, p. 0408; RT 2564:24-2565:25; RT 2674:17-2575:15 (Sing).)

a. Members "very commonly" reported calling up to ten different times about the same issue. (Exh. 678, pp. 2886, 2958.)

b. One member requested to speak to a customer service supervisor on five different occasions and was promised that he would be called back within 24 hours, but never received a call back. (RT 1727:21-1728:7 (Mr. R).)

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

126. New CSRs had far less expertise than their legacy PacifiCare predecessors and were unable to assist with "a high percentage of calls," even those asking "simple questions as to how a claim is paid." (Exh. 286; Exh. 287, p. 6168 [Mimick 5:05 p.m.].)

127. Members, providers, and employer groups complained of "horrible," "incompetent" customer service, including wait times of up to an hour and a half, provision of inaccurate information, and "outright rudeness." (Exh. 1065, p. 1102, ¶ 5 ["outright rudeness"]; Exh. 287, p. 6168 [inaccurate information]); Exh. 349, p. 6624 [inaccurate information]); Exh. 702; Exh. 717, p. 5404; Exh. 678, pp. 2771, 2797, 2801, 2805, 2831, 2836, 2838 ["horrible"], 2839, 2848, 2855, 2864, 2871, 2876; 2882, 2891; 2894 [1.5-hour wait], 2912, 2917 ["incompetent"]; 3028, 3071; RT 1726:2-1727:20 (Mr. R); RT 3378:21-3379:4 (Sing); RT 2674:15-21; 2668:14-2669:12 (K. Griffin).)

128. PacifiCare's focus on efficiencies led to a deterioration in customer service (Exh. 352; RT 3392:3-3393:5 (Sing)) that harmed consumers, providers, and employers.

129. PacifiCare did not remediate its flawed customer service for almost two years.

a. The company noted a "high level of customer service issues" in early 2007. (Exh. 285, p. 7085 [Berkel 7:27 p.m.].);

b. Shortly afterward, California brokers ranked PacifiCare as having "the least effective and courteous member services department."

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

130. The evidence supports the Department's contention that PacifiCare's degrading the performance of the customer service function reflects a lack of proper concern for members and constitutes a general business practice of placing cost-cutting ahead of the reasonable needs of members.

F. Mismanagement of Internal Systems and Processes

1. Refusal to Invest in Infrastructure Necessary for Compliance

131. The Department contends that PacifiCare made cost-driven decisions about internal systems and procedures that compromised its ability to conduct its business in a compliant manner.

132. Throughout 2006 and 2007, investment in PacifiCare's operational infrastructure was "significantly limited given the desire to immediately recognize synergies" (Exh. 461, p. 5526; Exh. 1034, p. 0509) and was characterized by "difficulty securing and remaining committed to capital/resources for legacy systems maintenance and integration execution" (Exh. 699, p. 4118).

a. **Changed Migration Plan**

133. The Department contends that PacifiCare failed to adequately maintain its internal systems out of an unrealistic expectation of swift migration off PacifiCare systems to United systems and that once those unrealistic expectations failed to materialize it failed to properly assess the support needs of systems it should have known it would continue to need for years to come. The Department points in support to PacifiCare's refusal to make investments in RIMS even after adjudicating RIMS claims on United's claim platform that were abandoned.

134. Once the company broadcast its synergy expectations to the public, it refused to make adjustments that would require significant investment, even when its "going in positions" proved untenable. (Exh. 1093, p. 17:28-18:3.)

135. At the time of the acquisition, the two companies planned to migrate claims processing off PacifiCare legacy claims platforms and onto United's platform, UNET (RT 11956:11-21 (Greenberg).), permitting the company to "sunset" PacifiCare's systems and save millions of dollars (Exh. 653, p. 3159; Exh. 523, p. 7765; Exh 647, p. 5875).

136. Through the Spring of 2006, PacifiCare continued to assume that PPO claims would migrate to UNET by June 2007 (Exh. 647, p. 5875; Exh. 651, p.2655; RT 8347:21-24 (Berkel)), but the head of the systems migration integration team warned his superiors that it "may not be realistic" to migrate all business over to UNET within a year or two. (Exh. 5395, p. 1649.)

137. In September 2006, PacifiCare formally abandoned its platform migration plans (Exh. 5399); but did not make any decisions about alternative plans for RIMS because "resources were diverted" to focus on NICE. (Exh. 5397, p. 0679; RT 11979:22-11980:11; RT 11981:25-11982:16 (Greenberg).)

138. PacifiCare executives recognized by late 2006 that it would be using RIMS to adjudicate claims for several years. (Exh. 526, p. 2770; RT 8418:17-8419:1; RT 7841:14-7842:1 (Berkel).)

b. **Refusal to Invest in RIMS**

139. At the time PacifiCare was realizing that it would not be rid of RIMS anytime soon, executives knew that the system was "antiquated" (Exh. 646, p. 6685; Exh. 625, p. 7075) and that legacy systems in general were "old" and "vulnerable." (Exh. 657, p. 7434; Exh. 5395, p. 1649; Exh. 695.)

140. Before the acquisition closed, PacifiCare, viewing its ancient systems as "United's problem," halted all upgrades, and curtailed IT spending. (Exh. 5265, p. 1941; Exh. 654, p. 3952; Exh. 655, p. 1630; Exh. 342, p. 8532.)

141. The version of RIMS PacifiCare was using was obsolete.

a. PacifiCare was on version 3.10 of RIMS at the time of the acquisition. (RT 14207:1 (Way).) At least by 2008, PacifiCare was the last company using that version. (Exh. 655, p. 1632.)

b. PacifiCare's use of the software was, in turn, dependent on other programs that were likewise obsolete and no longer supported by the vendors. (Exh. 655, pp. 1630, 1632.)

142. Upgrading to a more reliable release would have provided "a variety of data processing advantages," including a full relational database instead of a more error-prone flat-file structure, and heightened data security. (Exh. 1093, pp. 24:25, 25:17-26:10.) But PacifiCare would not pay the $1.3 million necessary to complete the upgrade (Exh. 655, p. 1632), despite its awareness that failure to invest in RIMS could cause operational and regulatory problems. (RT 8441:19-24 (Berkel).)

143. The upgrade would also have addressed RIMS' chronic underperformance in provider matching. This logic permits a claim engine to automatically match the provider listed on an incoming claim to a provider and fee schedule in the claim database.

144. Throughout 2006 and 2007, a significant number of RIMS claims had provider "match issues" that would have been prevented or reduced by the use of NPI. (Exh. 554; RT 19673:3-10; 19711:3-7 (Boeving).) These provider match errors caused PacifiCare to "fail the prompt pay laws of California." (Exh. 554, p. 0310 [Berkel 1:09 p.m.]; Exh. 365, p. 6870.)

145. In the summer of 2007, just as PacifiCare was acknowledging that it would be running RIMS for several more years (Exh. 526, p. 2770),

a. Ms. Berkel told United executives that PacifiCare systems had "not had adequate support since August 2005." (Exh. 460, p. 5410; RT 8126:21-8127:13.)

b. United admitted to its board that its focus on getting "business off PHS legacy systems" had caused the company to neglect the "existing operating environment" and that "reinvestment in IT infrastructure and maintenance efforts is required to support the business." (Exh. 457, p. 9245; Exh. 753, p. 4220.) Several months later, senior leaders again noted that "the legacy

PacifiCare platform has not been adequately maintained . . . to support ongoing operations, including regulatory requirements." (Exh. 342, p. 8532.)

146. By 2008, the vendors who leased RIMS and its associated software to PacifiCare no longer supported the versions PacifiCare was running and threatened to withdraw support. (Exh. 655, p. 1630; Exh. 656, p. 0208; Exh. 1093, pp.28-29; RT 8431:15-19 (Berkel).)

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

148. The company neglected RIMS in other ways.

a. RIMS was classified as a "Tier 2" application, meaning that the company tolerated a higher level of malfunctions and did not budget for an "on site manager" to coordinate responses to those malfunctions. (Exh. 1054, p. 5230.)

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

c. After the acquisition, PacifiCare stopped performing full backups of RIMS, relying on incremental backups that saved only the data that had been entered that day. (Exh. 1046, p. 5211 (number 19).) Full backups would have permitted prompt recovery after the 2007 outages. IT sought funding for full backups of RIMS soon after that outage, emphasizing that the existing

incremental backups placed RIMS at high risk. (Exh. 1044; Exh. 1045; RT 17977:20-17978:4 (Way).) Five months later, the request was "stalled"; eventually, it was abandoned. (Exh. 1048, p. 3773 [Dufek 8:56 p.m.]; Exh. 5558.)

149. The evidence shows that, in its pursuit of savings, PacifiCare failed to maintain RIMS in the condition appropriate for the functions of a claims platform.

c. **Conscious Neglect of Operational Infrastructure**

150. The funding allocated for PacifiCare operations was "minimal given the expectation that [PacifiCare] would begin migration by June of [2007]." (Exh. 524, p. 7482 [Ness 9:45 a.m.].) That allocation was not revisited after the company realized migration was "obviously not going to happen now." (Exh. 524, p. 7482 [Ness 9:45 a.m.]; Exh. 1093, p. 17:22-18:27.)

151. When serious problems arose, United leaders were "indifferent" to whether the resources that had been allocated were adequate to meet operational needs. (Exh. 543, p. 4755; Exh. 546, p. 8119; RT 8085:7-17 (Berkel).)

a. Decisions were "based on what systems and operations can do with minimal expense" rather than what was needed to process claims adequately. (Exh. 678, p. 3077.)

b. Business leaders were told that expecting additional capital to solve operational problems was "a sucker's bet." (Exh. 636, p. 3619, ¶ 3.)

c. For example, when it was discovered that it would cost $40,000 to fix a "ridiculous" "integration mistake," the response was simply, "we don't have budget to fix that." (Exh. 632, p. 9282; Exh. 709.)

152. PacifiCare's "Keep The Lights On" Committee, which sought to "do just the minimum" to keep PacifiCare systems running (Exh. 462; see also Exh. 525; Exh. 901, p. 4202; RT 5422:2-6 (Labuhn)), typified the company's approach underfunding PacifiCare's infrastructure.

153. Despite the representations to the Commissioner at the 2005 hearing about United's superior investment in technology, resources for technological solutions to PLHIC's operational problems were persistently scarce. (Exh. 929; Exh. 901, p. 4202, ¶ 2; Exh. 657, p. 7436; Exh. 524, p. 7486; RT 15351:4-15352:7 (Soliman).)

154. The consistent contemporaneous calls for more resources and criticism of the KTLO finding levels confirm a conscious policy on the part of PacifiCare to under-fund the internal systems below the levels judged by those responsible for them to be required.

2. CTN, Recontracting, Consolidation and Corruption of Provider Data

155. PacifiCare has cited in this hearing, as it did at the time, the loss of its leased provider network as a cause of the breakdowns it experienced. The Department disputes those claims and contends that PacifiCare misrepresented the circumstances surrounding the loss of the network in a groundless attempt to excuse or mitigate its violations.

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

157. Before the acquisition closed, United knew that the CTN lease could be terminated as soon as six months after close and was planning to replace the CTN network within that time. (Exh. 5343, p. 7737; RT 10791:19-10792:1; 10793:3-9; 10799:7-12 (McFann).)

158. One of the attractions for PacifiCare of acquiring PacifiCare lay in obtaining the PacifiCare provider network. (Exh. 426, pp. 8997, 8999, 9004 ["particularly in

California"]; RT 10836:22-10837:1 (McFann).) In late 2005, United began planning to replace CTN with PacifiCare's network, to contract with high volume CTN providers not already contracted with PacifiCare, and to "remediate" any PacifiCare contracts that did not allow access by PacifiCare affiliates, by June 2006 "or by termination date of the Network Access Agreement with CTN, whichever is first." (Exh. 5343, p. 7736.)

159. Termination of CTN did not affect PacifiCare members, who were already being served by PacifiCare's provider network, which became available to United with the acquisition. (Exh. 5252, p. 6928; RT 8046:3-8; RT 10348:4-14 (Berkel).)

160. However, United deemed there to be "gaps" in the PacifiCare network's coverage that disadvantaged United members, so United embarked on a program to recontract CTN providers.

161. The ensuing recontracting effort was not, however, limited to executing contracts with high volume "gap" providers (those who had served United members through CTN but were not contracted with PacifiCare). Instead, the company also sought to "remediate" existing PacifiCare contracts with "unfavorable economics" (Exh. 5343, p. 7736; RT 5070:6-12 (McFann)), encouraged all PacifiCare physicians to sign United contracts (Exh. 467, p. 1356, [number 11]), and targeted physicians who had previously belonged to neither network. (Exh. 629, p. 1966[3rd bullet in first paragraph]). As a result, United signed new contracts with over 9,000 providers in 2006 and early 2007 (Exh. 5252, pp. 6928, 6929), double the number necessary to fill the CTN "gap." (Exh. 622, p. 677.)

a. **Contract Loading Delays**

162. More than two-thirds of the contracts that PacifiCare/United executed in 2006 and early 2007 were loaded into its claims systems more than 30 days after the effective date of the contract. (Exh. 5252, p. 6929.) PacifiCare insisted that the providers agree to "hold" claims indefinitely until the new rates were loaded and forgo any interest to which they would be legally entitled for late payment. (Exh. 862, p. 5500 [number 2]; Exh. 5352; RT 2206:19-2207:14; 2208:8-16; 12885:15-25 (McFann).)

163. Ms. Berkel testified that the company programmed RIMS to "hold" claims for existing providers until the new rates were loaded, but internal documents showed that claims were paid and then reworked later because the "hold" function was too "manual" to be reliable. (Exh. 528, p. 2688 [See1st bullet under "CA Retro Contracts/RIMS Re-work projects –Ellen"..) RIMS could not be adjusted to hold claims for newly contracted providers. Their claims were therefore processed as out-of-network despite having executed a contract. (RT 9931:24-9932:14 (Berkel).) In any event, many providers submitted claims before their new contracts were loaded and were paid at outdated or out-of-network rates. (RT 2209:22-2210:9 (McFann).)

164. The contract uploading process was plagued with errors and miscommunication between staff in Network Management ("NM"), who negotiated and executed the contracts, and Contract Control and Installation ("CCI"), who reviewed and uploaded the contract data. (RT 2214:1-16; 2215:22-2216:6; 2221:7-10 (McFann).) The staff responsible for uploading the fee schedules were inexperienced, and PacifiCare did not have adequate server space to upload a significant number of fee schedules at once. (Exh. 962 [Smith 3:28 p.m.]; Exh. 963; RT 16294:22-16925:13 (Lippincott).)

b. **EPDE**

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

166. There was no technical or operational imperative to use EPDE. (RT 15257:17-25 (Lippincott); RT 21336:3-10 (McNabb).) PacifiCare continued to "dually maintain" (separately update) provider data for the remaining legacy PacifiCare states until

late 2007, and for PacifiCare's other platforms long thereafter. (RT 15056:24-15058:6 (Lippincott).)

167. It was not the case, as PacifiCare claimed, that termination of the CTN lease "necessitated creating a single source of truth." (Exh. 5615, p. 4.)

168. PacifiCare knew that it was a decision fraught with risk. (Exh. 395, pp. 1149, 1222; Exh. 914.) During each nightly EPDE feed, every record that had been changed since the last feed was transmitted to RIMS and overwrote RIMS records.

169. Because every data transfer presents risk of erroneously changing thousands of records, data bridges are generally regarded as a temporary tool that is usually not employed when the user has control over both the source and destination databases, as PacifiCare did in this case. (Exh. 1093, p. 27:16-19; RT 16067:8-20 (Lippincott).)

a. A Network Data Management executive noted that EPDE was a "band aid" and that the company should "establish a direct connect [from NDB] if a platform will be with us for a little while." (Exh. 947, p. 0396.)

b. PacifiCare never considered building a "direct connection" to allow RIMS to access the data in NDB necessary to adjudicate each claim, which it deemed too expensive. (RT 16067:21-16068:6 (Lippincott).)

170. PacifiCare's hasty implementation of EPDE exacerbated the risks inherent in the data bridge.

a. High level executives ignored internal warnings about the "questionable data" acquired from CTN and "the potential to overwrite clean records in RIMS with bad NDB data." (Exh. 773, p. 2319; RT 10998:23-11000:14; 11002:3-11003:18 (McFann).)

b. Twenty percent of California data in NDB was incorrect when EPDE launched. (Exh. 767, p. 3316.) But the company failed to assess and reconcile data discrepancies between RIMS and NDB before implementing the feed (Exh. 769, p. 6084; Exh. 713, p. 9518; RT 12766:8-12767:14 (McFann)) and

only later recognized that the CTN data it was using to overwrite RIMS records was "awful" (Exh. 774, p. 1293).

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

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

b. This error should have been, but was not, identified in the planning and testing stage. (RT 16158:7-16 (Lippincott).)

172. The company did not adequately test the EPDE process before implementing it. (Exh. 921; Exh. 769, p. 6084; RT 8231:3-9 (Berkel); Exh. 388, p. 4954 [single day of system testing, user acceptance testing; skipped integration testing]; RT 4036:2-20 (Barbati); Exh. 921, p. 5189 [Lippincott 12:39 a.m.: in retrospect, should have tested further upstream, downstream].)

a. PacifiCare conducted such minimal training that the EPDE team itself did not understand the basics of how the process worked. (Exh. 602, pp. 1240-1241; Exh. 898, p. 4739; RT 10993:9-10994:17; 12841:1-19 (McFann); RT 16481:23-16482:15 (Lippincott).)

b. A full year after implementation, the staff attempting to solve data corruption caused by the EPDE feed remained unfamiliar with the fundamental elements of the process. (Exh. 948, p. 5403; RT 15022:24:15023:6; RT 16089:7-20 (Lippincott).)

173. Starting when it launched in June 2006, and continuing into 2008, EPDE corrupted provider data in RIMS, causing contracted providers to be paid as non-participating and vice-versa (Exh. 8 at 1869; Exh. 480; Exh. 481; Exh. 501; Exh. 954, p. 2782; Exh. 354, p. 7184) and erasing entire data fields, resulting in significant mispayment of claims. (Exh. 475; Exh. 476; Exh. 477; RT 4935:1-4936:17 (McFann); Exh. 479 [result was underpayment]; RT 4950:14-23, 4952:1-3 (McFann); Exh. 481 [provider terminated, not discovered for 4 months].)

174. RIMS data was so corrupted by August 2006 that the idea of using RIMS to generate provider directories was dismissed as "crazy talk." (Exh. 775, p. 2803 [McFann 7:35 p.m.]; RT 11015:6-22 (McFann).) Nine months later, RIMS data was still so riddled with errors that PacifiCare again could not rely on RIMS to print directories. (Exh. 957, p. 8305.)

175. PacifiCare had originally planned to add all other legacy PacifiCare states to the RIMS EPDE feed in August 2006, but postponed implementation in the other states because the effect on California data was so disastrous. (Exh. 392, p. 2150; Exh. 953, p. 4704 [Berkel 9:44 a.m.]; RT 5042:2-18 (McFann).)

a. When the company finally implemented the other states in October 2006, it caused "a huge mess" — providers were "paid non-contracted and to wrong addresses," just as they were in California. (Exh. 507, pp. 3923-3924.)

b. PacifiCare discontinued the EPDE feed for these states and continued to dually maintain their RIMS data for at least another year. (Exh. 5539.)

c. There is no indication that PacifiCare even considered doing the same for California provider data.

c. **Failure to Maintain Fee Schedules**

176. United was aware before the acquisition that PacifiCare's "thousands" of nonstandard fee schedules "take[] time and effort to [build] correctly." (RT 10674:20-24; 10681:7-10; 12961:12-13 (McFann).)

177. For months following the acquisition, PacifiCare failed to maintain RIMS fee schedules and the "crosswalks" that linked fee schedules in RIMS to the corresponding fee schedules in NDB.

a. In March 2007, PacifiCare realized that no one had been maintaining the nonstandard fee schedule crosswalk, which housed the majority of PacifiCare fee schedules, and that dozens of the standard fee schedules were also incorrectly linked. (Exh. 497, pp. 9764-9765; RT 10861:7-9 (McFann).)

b. This "embarrassing" and "avoidable" situation would have been prevented by "much more rigor" around "operational flows." (Exh. 497, p. 9763 [McFann 9:21 p.m.]; RT 16266:5-16268:2 (Lippincott).) As Ross Lippincott, the "owner" of the end-to-end EPDE process, observed, it was "hard to believe it's mid-March and we are just now realizing a key operational process hasn't been followed this entire time." (Exh. 959, p. 8289 [Lippincott 1:16 p.m.]; RT 15185:24-15186:2 (Lippincott).)

d. **United Front End**

178. The Department contends that difficulties with modification to the electronic data interchange ("EDI") systems by which providers submitted non-paper claims, reflect PacifiCare's business practice of inadequately planning, testing, and monitoring changes to claims-data systems.

179. Samia Soliman, former Vice President, Application Development at PacifiCare and, for three years after the acquisition, at United (Exh. 925) testified about a problem encountered when United decided to alter the front-end programs through which claims and other documents had to pass to reach PacifiCare's claims-paying platforms.

180. Prior to the acquisition, PacifiCare had a "preprocessor application that would handle the EDI transactions before they go anywhere else." (RT 15365:25-15366:6 (Soliman).) That preprocessor would identify missing information and fill that information in, based on data maintained for each provider. (RT 15366:7-18 (Soliman).) It would then

go to a gateway and be distributed to one of the PacifiCare claims-paying platforms. (RT 15367:17-22 (Soliman).)

181. United imposed a new front-end, the United Front End ("UFE"), which did not provide the same data-filling-in function as the PacifiCare preprocessor, which was no longer used. (RT 15367:3-10.)

182. From UFE, if the claim was a PacifiCare transaction, it would go to the PacifiCare gateway, bypassing the PacifiCare preprocessor. (RT 15367:11-16, 23-25 (Soliman).) But if the claim was missing the information that the PacifiCare preprocessor formerly filled in but UFE did not, then when it hit the claims platform it would error out and not get processed. The claims then got lost because they went to a file that "nobody was tending or watching or looking for the rejects." (RT 15370:12-14 (Soliman); see also Exh. 930.)

183. Ms. Soliman testified that the problem could have been prevented by more testing, but she and her team were constantly rebuffed when asking for more testing of new systems. (RT 15382:2-17 ["My testing budget was curbed, . . . [a]nd my testing duration was [limited]"].)

184. She also testified that the problem could have been detected by appropriate end-to-end reconciliation processes. (RT 15369:21-15370:2.)

185. Ms. Soliman also testified that the problem could have been remedied after the fact had anybody been monitoring the transactions, but "nobody was tending or watching or looking for the rejects, neither automated nor manually." (RT 15370:10-14.)

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

187. Ms. Soliman also testified that the errors in implementing UFE were representative of those fostered by United's fall-forward policy (RT 15354:17-15358:25; RT 15361:3-15362:19; RT 15375:18-15378:3) and were exacerbated by budget cuts and loss of personnel (RT 15351:4-15352:16; RT 15377:21-15379:2; RT 15382:18-15383:6).

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

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

189. The Department contends that the inaccurate provider data in RIMS are evidence that PacifiCare neglected to establish and implement rudimentary standards or risk-mitigation strategies for handling contracts and provider data, failed to invest in adequate staff and quality-control resources, failed to promptly analyze defects and address their root causes, was willing to let the provider community bear the brunt of known data corruption, and maintained a siloed organizational culture in which avoidance of blame was paramount to problem-solving.

Failure to Manage the Process and Personnel for Handling Contracts

190. PacifiCare provided its staff with "no documented process flows" for loading contracts or physician rosters or for linking doctors to the right fee schedules. Staff was given conflicting instructions for contract loading and no path for resolving problems that arose in the contract loading process. (Exh. 787.)

191. Legacy PacifiCare Network Management staff submitted incorrectly configured contracts because they were not trained to use Emptoris, the contract-generating and loading tool that fed data to NDB. (Exh. 342, p. 8526.)

192. The months-long neglect of the fee schedule crosswalks was the result of the lack of "a clear process on loading fee schedules [and] updating crosswalks" (Exh. 497, p. 9764 [Feng 1:04 p.m. (number 2)]) and the failure to properly audit fee schedules after they were constructed (Exh. 491, p. 1252; RT 10296:4-12 (Berkel)).

Failure to Timely Remediate Defects

193. Shortly after the EPDE feed began, PacifiCare staff began complaining of the "widespread impact" of "questionable data" (Exh. 773, p. 2319) and expressed "frustration" that the "data integrity issue" was not being investigated. (Exh. 775, p. 2803 [Gates 4:34 p.m.].)

194. By early 2007, EPDE had contributed to an "all time high" of aged RIMS inventory and rework. (Exh. 544, p. 6721 [Berkel 7:27 p.m. (4th paragraph)].) The company failed to take corrective action for months.

195. By August 2006, PacifiCare realized that the EPDE process had sufficiently serious problems that it postponed expanding it to other states (Exh. 953, p. 4704 [McFann 9:58 a.m.]; Exh. 775, p. 2803 [McFann 7:35 p.m.]) and recognized that changes to the feed were required (Exh. 435, p. 3699 [date of 8-8-06, "changes to EPDE required" (See bullet "CTN Migration")]).

196. In January 2007, the company conducted an "all day deep dive" to review EPDE logic and identify corrective actions. (Exh. 950 [Rao 10:04 a.m.].)

197. Yet the first coding adjustment to fix known logic errors, which PacifiCare called an "enhancement," was not implemented until March 2007. (Exh. 921, p. 5189; Exh. 916, p. 9427 [number 4].)

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

199. PacifiCare promised to remedy its contract-loading deficiencies following the market conduct exam. (Exh. 118, p. 3423.) A year later, however, Ms. Berkel predicted that reworks and provider appeals "will increase" "because we have not corrected our internal control framework" for contract loading. (Exh. 637 [Berkel 9:52 a.m.].)

200. In March 2009, Mr. McMahon called an assessment of PacifiCare's progress on these corrective actions "brutal," observing that "there are no quantitative measures of success and we are behind on all" corrective actions for contract loading. (Exh. 715, p. 3204 [McMahon 9:59 a.m.]; Exh. 714, p. 1635; RT 9909:3-12 (Berkel).)

201. PacifiCare did not timely or voluntarily rework provider claims that had been paid improperly as a result of late contract loading. (Exh. 5265, p. 1945; Exh. 118, p. 3423.)

Lack of Data Reconciliation and Reporting

202. PacifiCare fixed individual data errors when providers complained about them but did not attempt to identify the full scope of corrupted data, did not analyze root causes, and did not allocate resources to fixing all the errors causing inaccurate claims payments.

203. Records that had been fixed were often corrupted again by the next feed, requiring staff to "correct[] provider records over and over again." (Exh. 501, p. 5935 [Chan 2:27 p.m.].)

204. Even after the fee schedule crosswalk was found to have been neglected for months, a deficiency Elena McFann called "avoidable" and "embarrassing" (Exh. 497, p. 9763 [McFann 9:21 p.m.]), the company did not swiftly remediate it, and the company failed to maintain fee schedules on several later occasions. (Exh. 266, p. 6987; Exh. 970, p. 9675 [Mimick 7:18 a.m.]; Exh. 808, Exh. 763; RT 2260:2-9 (McFann).)

205. Shortly after EPDE went live, providers began complaining that reimbursement checks were being sent to outdated addresses, even though PacifiCare had previously been sending payment to the proper address. (Exh. 1021, p. 0280 [Jan. 26, 2007, 3:53 p.m., e-mail from Black].)

a. In late 2006, several PacifiCare employees noted this phenomenon, and one suggested, to no avail, that a report be run to identify all the providers affected. (Exh. 495.)

b. CDI and the California Medical Association ("CMA") independently raised the issue with PacifiCare in early 2007. (Exh. 1021; Exh. 5, p. 0705.)

c. The company continued to receive internal indications that an EPDE error was changing provider addresses in RIMS but refused to investigate the root cause because NDB was the "source of truth," "so regardless of what was previously in RIMS, it's good now." (Exh. 850, p. 8067; Exh. 354, p. 7184 [number 17].)

d. This tautology was unconscionable in light of the company's awareness that inaccurate data in NDB had, and was continuing to, corrupt RIMS data (RT 15129:18-15130:3 (Lippincott)).

e. The company did not identify the structural defect causing returned checks, which were not paid within 30 working days, until April 2007. (Exh. 917.)

206. By late 2006, PacifiCare had recognized the need for stronger quality controls to prevent data defects from being introduced at the various handoff points between contract loading, NDB, and RIMS, yet the company took no action to tighten controls. (Exh. 759, p. 6084; RT 16305:17-20; 16332:21-16333:22 (Lippincott).)

207. In April 2007, the company again acknowledged the acute absence of quality measures for the transmission of data from Emptoris to NDB and for the EPDE feed from NDB to RIMS. (Exh. 965, pp. 5838, 5840.)

208. PacifiCare did not established a "war room" to track data corruption problems related to EPDE until June 2007, a year after the feed began (Exh. 602, p. 1241), and did not begin regularly reviewing "EPDE quality metrics" until September 2007. (Exh. 602, pp. 1238, 1245.)

209. The need for these reconciliation and reporting activities was foreseeable in June 2006; if PacifiCare had implemented at that time and consistently applied them thereafter, many mispaid claims could have been avoided. (RT 8247:8-13; 8252:25-8253:1 (Berkel).)

210. The sporadic, ad hoc reconciliation reports that PacifiCare used before September 2007 were often ignored because the company did not establish standards or allocate responsibility for monitoring the reports. (Exh. 968, p. 8487 [Jul. 19, 2007, 11:09 a.m., e-mail from Lippincott]; Exh. 970, p. 9675 [Mimick 7:18 a.m.]; Exh. 665, p. 4133 ["who owns the report?" (See "Business Requirements")]; RT 16381:14-15 (Lippincott).)

211. Even reports created to monitor specific logic flaws known to be corrupting provider records, or brand-new code that had just been put into production, were not

monitored. (Exh. 503, p. 1380 [Mimick 3:29 p.m.]; Exh. 969, pp. 4808- 4809 [Rao 3:07 p.m.]; RT 16376:12-23 (Lippincott).)

212. The enhanced reports that PacifiCare developed in August 2007 were inadequate. (Exh. 977 [Mimick 7:40 a.m.]; RT 16432:6-21 (Lippincott).)

a. In October 2008, and again in March 2009, the company lamented the inadequacy of the reconciliation reports and quality controls to prevent demographic and contract data defects. (Exh. 699, p. 4154; Exh. 714, p. 1635 [number 5].)

b. The company never developed proper controls or testing capacity for Emptoris, despite having acknowledged for years the need for enhanced testing. (Exh. 966, pp. 2470-2471 [McKonnel 6:47 a.m.]; Exh. 771, p. 5858 [Kaja 10:21 p.m.].)

213. The company also failed to correct data errors promptly, allowing them to languish for months while claims were incorrectly paid. (Exh. 8, pp. 1865-1868; Exh. 497; Exh. 509; Exh. 5354, pp. 8205 (Dr. Sun), 8206 (Dr. Castellanos), 8207 (Dr. Borok and Women's Healthcare); Exh. 477; Exh. 481 [provider terminated, not discovered for four months].)

a. The company did not attempt to systematically assess the accuracy of RIMS data until August 2007. (Exh. 602, p. 1239.) By that time, PacifiCare employees had been begging their superiors for months to undertake a "rigorous audit process to ensure the integrity of data" (Exh. 789, p. 7224) rather than "continue to rely on the provider community to discover our issues for us" (Exh. 956, p. 5196 [Mimick 10:02 a.m.].)

b. The company had also, months earlier, acknowledged that "dated provider demographic data in NDB needs extensive cleaning." (Exh. 965, p. 5840.)

Silos and Lack of Accountability

214. The Department contends that management of the contract loading process and EPDE was characterized by hostility among departments whose cooperation was crucial to success.

215. The company failed to designate responsibility for researching the root causes of errors. (Exh. 856, pp. 1709 [See "Current Process Controls"]; Exh. 665, p.4133; RT 12834:25-12835:7; 12837:23-12838:6; 12839:10-14 (McFann).)

a. As a result, the company faced a backlog of almost a thousand unresolved provider data inquiries in January 2007, most of them over two months old. (Exh. 767, p. 3323.)

b. A year later, there were still provider data issues that had "been on a list for 6 months or more with no traction," due to "a gap in the organizational structure" and unwillingness by staff to "step out of their roles to engage the UHC organization." (Exh. 979, p. 3701.)

216. United executives also focused on avoiding blame for data corruption rather than taking ownership and fixing problems.

a. The director of CCI complained that others "put the accountability on me to try and figure out what the root cause is when the people who created/implemented this process should be explaining to me what they are doing to corrupt my records in RIMS." (Exh. 501, p. 5933 [Chan 9:40 a.m.].)

b. Mr. Lippincott was preoccupied with "trying to clear EPDE's name" by attributing problems to the legacy PacifiCare Autoload program, although modifications to that program fell within his area of accountability. (Exh. 919, p. 5200 [Lippincott 12:42 a.m.]; Exh. 1093, pp. 9:11-10:23.)

c. He dismissed criticisms as "EPDE lore" (RT 15030:7-15032:4 (Lippincott)) and insisted that "EPDE isn't the root cause of X problem" even before the root cause could be determined. (Exh. 953, p. 4704 [McFann 9:58 a.m.].)

d. During the hearing, Mr. Lippincott continued to insist that he bore no responsibility for the data corruption detected in the market conduct exam. (RT 15191:23-15193:12; 15195:17-25; 15199:21-15201:5.)

217. The refusal to transcend organizational boundaries hindered resolution of serious problems. Because PacifiCare never established a "dedicated single point of contact" to supervise and coordinate the activities involved in contract loading and provider data, all process improvements were "transactional or reactionary" rather than proactive. (Exh. 699, p. 4152.)

Layoffs and Inadequate Resources

218. The Department contends that many of these operational deficiencies, and the glacial pace of remediation, can be traced to PacifiCare's excessive layoffs, failure to retain knowledgeable staff, and refusal to devote adequate resources to maintaining PacifiCare's claims payment infrastructure.

219. Every department involved in contract loading and maintenance of provider data was understaffed.

a. Network Management, which negotiated contracts and managed many of the provider data issues, had been "reduced through attrition" (Exh. 717, p. 5404 [See bullet 3 in "Background"]) and "had triple the workload with the same staff." (Exh. 5265, p. 1948.)

b. CCI, which reviewed contracts and uploaded the data into NDB, was "overwhelmed," "backlogged" and "overloaded due to layoffs." (Exh. 510, pp. 1301-1302, 1304.) CCI was "at least 6 weeks behind" in loading contract information because the company did not replace CCI staff that had left, even as the "floodgates [were] opening for remediated contracts." (Exh. 510, p. 1304; Exh. 760 [Stewart 9:36 a.m.].)

c. The Integration and Technology Operations ("ITO") unit, which was responsible for EPDE, did not increase staffing despite "continued aggressive

acquisition activities" that it knew would "stretch resources beyond capacity." (Exh. 984, pp. 9814, 9827.)

220. It is reasonable to infer that the company's failure to undertake data reconciliation efforts until late in 2007 is attributable to the absence of "resources to perform historical clean-up or structured, pro-active 'true-up.'" (Exh. 699, p. 4152; RT 9897:3-17 (Berkel).)

221. Even after the failure to maintain fee schedules was identified, the company did not allocate sufficient resources to thoroughly examining each fee schedule. (Exh. 491, p. 1255.)

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

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

224. The refusal to budget for maintenance of legacy PacifiCare systems and for technology development necessary for integration significantly delayed remediation of known EPDE errors.

a. The strict limit on funding for technology fixes prevented needed code enhancements "from being operationalized." (Exh. 984, p. 9827; Exh. 524, p. 7482.)

b. When PacifiCare first began assessing the logic flaws in EPDE in January 2007, there was no funding for EPDE updates (Exh. 950 [Rao 10:04 a.m.];

Exh. 447, p. 6385.) As a result, the first "enhancements" did not occur until March and April of 2007.

c. Projects planned for 2008 to improve data accuracy were sacrificed to budget limits. (Exh. 981, p. 9023; Exh. 982, p. 6087; Exh. 983, p. 1316.)

225. The evidence shows that PacifiCare's mismanagement of the contract data-entry and data-maintenance functions, siloing of staff, staff refusal to assume accountability for errors, PacifiCare's failure to adequately plan and test new systems, PacifiCare's failure to adequately monitor processes and reconcile data, PacifiCare's failure to designate specific staff to be responsible for systems and data, and PacifiCare's failure to timely remediate defects led to the corruption of provider data and consequent violations in the handling of provider data.

G. The Result: "Integration Speed, Savings, Quality — Pick Two. We Missed on Quality"

226. In 2006, Uniprise, the operations arm of United that "paid the claims and answered most of the phone calls" (RT 15485:8-19 (McMahon)) "hit its IOI based upon the fine work to drive cost out of PHS." (Exh. 546, p. 8116 [Auerback 9:02 a.m.].)

227. As of June 30, 2007, United had achieved a total of $950 million in integration run rate synergies — $365 million of which was attributable to "operating efficiencies." (Exh. 457, p. 9242.)

a. The "operating efficiencies" included reduced costs of corporate infrastructure and information technology. (RT 11245:13-22 (Berkel).)

b. That figure does not include any "growth synergies" or increased revenue. (RT 18407:9-18408:19 (Wichmann).)

228. United consider the integration a success. (E.g., RT 15872:24-15873:12 (Wichmann) ["satisfied with the way United executed the PacifiCare integration," which was "a success" from shareholder, member, and provider standpoints].)

229. United's express satisfaction demonstrates a low regard for the service and compliance issues its executives acknowledged at the time. (See, e.g., appears not to be

diminished by the recognition that the synergies were achieved "at the cost of excellent customer service and claims payment." (Exh. 450, p. 5417 [synergies were achieved "at the cost of excellent customer service and claims payment."]; Exh. 662, p. 3216 [McMahon 11:48 a.m.: company's "overzealous" pursuit of synergies drove PacifiCare's numerous operational problems.]; RT 8074:18-8075:11 (Berkel) [resource scarcity contributed to violations in this case].)

230. As Ms. Berkel wrote in her 2007 lessons-learned appraisal: "Integration Speed, Savings, Quality — Pick Two. We missed on Quality." (Exh. 5265, p. 1939.)

H. Complaints, Regulatory Response, Company Evasion

231. In October 2006, CDI began noticing a spike in complaints from consumers and providers about PacifiCare's claims-handling practices, primarily focused on mispaid claims and claims that had been wrongly denied based on pre-existing conditions. (RT 52:22-53:16; 58:14-59:2 (Smith); Exh. 5003.)

232. After closure, communications with PacifiCare were seriously impaired.

a. Consumers also complained, and the company has confirmed, that for a period phone calls to the company went completely unanswered. (RT 57:15-20 (Smith); Exh. 5265, p. 1945.)

b. When CDI compliance officer Nicoleta Smith repeatedly attempted to reach someone in PacifiCare's claims department to discuss the complaints, no one answered the telephone and she was unable to leave a message. (RT 54:3-56:8 (Smith).) Ms. Smith finally received a return phone call from a PacifiCare representative, Sharon Hulbert, with whom she initiated a discussion about the complaints the Department had received. (RT 55:24-57:25 (Smith).)

233. The number of complaints continued to increase dramatically in the following months. (RT 195:14-23 (Smith).)

a. In early 2007, CDI's Claim Services Bureau ("CSB"), a unit within the Consumer Services Division, assigned several experienced compliance officers to systematically investigate the complaints it was receiving about

PacifiCare's claim-handling practices. (RT 69:17-70:3; 181:16-19; 224:13-17 (Smith).)

b. The Department notified PacifiCare at that time that its investigation of consumer complaints had revealed troubling patterns of noncompliance. CDI requested a detailed corrective action plan and a timeline for its completion. (Exh. 5004.)

c. Over the course of 2006 and 2007, CDI compliance officers issued numerous of violation letters confirming the results of their complaint investigations and citing the company for hundreds of violations. (Exh. 36; Exh. 39; Exh. 46; Exh. 47; Exh. 48; Exh. 49; Exh. 54; Exh. 55; Exh. 57; Exh. 59; Exh. 61; Exh. 63; Exh. 68; Exh. 70; Exh. 72; Exh. 74; Exh. 75.)

234. At PacifiCare's request, representatives of the company participated in a conference call with CDI compliance staff at the end of January (RT 71:4-10 (Smith); Exh. 4, p. 7940), but did not answer the Department's questions or furnish timelines for completing corrective actions. (RT 77:21-79:7; 82:11-83:5 (Smith).)

235. In early March 2007, several high-level PacifiCare executives gave a presentation to CDI staff about "challenges" the company was "overcoming" in connection with the "integration" of PacifiCare into United, and their relationship to the complaints CDI was receiving from consumers and providers. The company identified United's loss of the leased Care Trust Network (CTN) as the primary cause of claims-processing problems. (Exh. 8, p. 1865; Exh. 5013, p. 9677 [Masters 9:52 a.m.]; RT 122:23-123:2 (Smith).)

236. The company was not forthright with the regulators about the role that the Lason outsourcing played in the service breakdowns that triggered so many complaints.

237. In early March 2007, several high-level PacifiCare executives gave a presentation to CDI staff about "challenges" the company was "overcoming" in connection with the "integration" of PacifiCare into United, and their relationship to the complaints CDI was receiving from consumers and providers.

238. During the March 2007 PacifiCare-CDI meeting to address consumer complaints and integration issues, the company was aware that serious errors in the transition of mail routing to Lason were affecting claims, appeals, customer service, and provider disputes. (Exh. 5258, p. 7105.) Yet PacifiCare chose not to reveal this information to CDI in the course of the meeting. (RT 7568:20-7569:3 (Berkel).)

239. Throughout the first half of 2007, the CSB PacifiCare team met regularly with PacifiCare staff to discuss the claim-handling practices revealed by consumer and provider complaints. (RT 112:14; 118:18-22; 153:3-7; 162:2-13; 177:10-25 (Smith).)

a. CDI asked PacifiCare to identify the extent and root causes of noncompliance and requested detailed corrective actions, including reprocessing of wrongly denied and mispaid claims. (Exh. 3; Exh. 4; Exh. 5; Exh. 6; Exh. 7; Exh. 11; Exh. 17; Exh. 5017; RT 84:18-21; RT 106:21-108:22; RT 110:4-115:8; 153:3-7 (Smith).)

b. Susan Stead, a former regulator with the Ohio Department of Insurance testifying on behalf of PacifiCare, lauded CDI's efforts to address PacifiCare's noncompliance. (RT 24510:13-25; 24484:1-24487:20; 24493:1-14; 24495:15-24996:11 (Stead).)

240. PacifiCare periodically provided responses to the Department's inquiries and updated the Department on its corrective action efforts. (E.g., Exh. 5006; Exh. 5007; Exh. 5008.) However, the company frequently failed to meet deadlines it had established for completing corrective actions. (E.g., Exh. 17, p. 7377 [number 1]; Exh. 15, p. 0477 [number 8]; RT 173:19-25 (Smith).)

a. While PacifiCare was "responsive" in terms of its willingness to meet with CDI, "the meetings did not really result in substantive resolutions" to the issues CDI raised. (RT 464:10-19 (Smith).)

b. Laura Henggler, CDI's primary contact at PacifiCare, was "not very helpful" and appeared uninformed about basic claims-processing matters. (RT 153:9-154:4 (Smith).)

241. Over the course of CSB's investigation, PacifiCare made several misrepresentations about its integration activities and their causes. For example, PacifiCare deliberately obfuscated the circumstances around the corruption of fee schedules (compare Exh. 623, p. 3205, with Exh. 622, p. 0678) and misrepresented the circumstances and consequences of the termination of the CTN lease.

242. CDI compliance officers grew frustrated that the noncompliance they had brought to the company's attention was not promptly addressed. (RT 112:8-16; 115:9-22; 159:3-160:1 (Smith).)

243. Compared to other health insurers with whom Ms. Smith had worked on compliance issues, PacifiCare's progress on corrective action plans was "very slow" and the volume of compliance issues grew rather than shrinking over time. (RT 178:21-179:23 (Smith).)

244. In Spring 2007, the CMA, an organization representing independent physicians and physician groups (RT 1243:18-23 (Black)), and the University of California Medical Centers filed complaints with the Insurance Commissioner calling for an investigation of PacifiCare's claim-handling practices. (Exh. 165; Exh. 5155.)

a. These complaints indicated that PacifiCare had not addressed the compliance problems CDI had been discussing with the company for several months.

b. When a compliance officer asked PacifiCare about the estimated timeframe for resolving the compliance issues that CDI had addressed, Ms. Hulbert responded that it would take three to five years to resolve these acquisition-related problems, and that it would be "cost prohibitive" to do so more quickly. (RT 118:11-17 (Smith).)

245. The large volume of consumer and provider complaints and the compliance issues the CSB investigation had uncovered prompted CDI to consider a targeted exam. (Exh. 5171, p. 4289; RT 267:19-268:6 (Smith); RT 600:9-20 (Vandepas); RT 14067:24-14068:16 (Laucher).)

246. Around April 2007, CDI and the Department of Managed Health Care ("DMHC") began planning coordinated targeted examinations of the PacifiCare legal companies within their respective jurisdictions (Exh. 5408; RT 11451:6-10 (David)), and notified the company of the planned exam shortly thereafter (Exh. 891).

247. During the course of the examination, CDI sent PLHIC several "referrals" to clarify the circumstances of particular transactions, practices, or data. (RT 619:1-13 (Vandepas); Exh. 106; Exh. 107; Exh. 108; Exh. 110; Exh. 111; Exh. 121.)

248. In several responses to referrals, the company deliberately suppressed or distorted information.

a. For example, when the Department asked about staffing trends for claims-processing staff, PacifiCare deliberately withheld the primary reason for turnover, which was dissatisfaction with benefits and overtime. (Exh. 363; RT 3509:17-3510:4 (Norket).)

b. In another referral, CDI asked about the root cause of the company's failure to timely process provider disputes. PacifiCare acknowledged internally that its noncompliance in this area was due to the document routing system it implemented after the acquisition, but decided not to share this information with the Department. (Exh. 358, p. 9596.)

249. In accordance with Insurance Code section 734.1, CDI transmitted to PacifiCare the verified written reports of the MCE on or about November 9, 2007. (Exh. 116; RT 907:1-16 (Vandepas).) PacifiCare was given 30 days to make a written submission or rebuttal to the reports, as provided for by section 734.1, subdivision (a). (Exh. 116, p. 1411.)

250. On or about December 7, 2007, PacifiCare issued its responses to the verified written reports of the MCE, admitting to approximately 130,000 violations of law, and disputing other findings. (Exh. 117; Exh. 118; RT 662:15-663:18 (Vandepas); RT 7778:21-7779:1 (Berkel).) Where PacifiCare disagreed with the number of violations cited in the

draft report, the final report was revised to accept PacifiCare's figure. (RT 666:10-669:6 (Vandepas); compare Exh. 1 with Exh. 117, Exh. 118.)

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

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

III. LEGAL FRAMEWORK

253. No findings of fact are being sought here relating to this section of CDI's Opening Brief.

IV. VIOLATIONS OF LAW AND RECOMMENDED PENALTIES

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

1. PacifiCare's Violations of Law

254. As far back as 2005, PacifiCare's practice when it received a claim from a new member with a treatment code that corresponded to a potential pre-existing condition was to automatically close or deny the claim and to issue a denial letter requesting a copy of the COCC. (CDI Opening Brief ("CDI OB"), part IV.A.2.a.)

255. For several years from at least 2006 through 2007, PacifiCare's process for receiving and processing COCCs did not work appropriately, causing claims to be improperly denied. (See CDI OB, part IV.A.2.b.)

a. In a February 2007 corrective action workplan, for instance, PacifiCare described the problem with its COCC process:

> "There appears to be a tracking issue that arises when Certificates of Creditable Coverage are sent into the company. The members consistently report sending in the certificates on several occasions and for one reason or another, there is no way for claims or MAS to cross share the certificates or keep them entered into a central location for all staff to review. Or they are simply 'lost'. In any event, the members claims end up being denied for lack of 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.)

b. A subsequent corrective action plan, last updated March 20, 2007, explained that the company lacked a consistent process for handling its COCCs:

> "Lack of a consistent process to house, track and/or retrieve COCCs received from members. This is especially problematic when it occurs between Group Services, Customer Service and Claims — as it results in claim denials for pre-existing coverage conditions due to lack of the receipt of a COCC. This has occurred even though members report mailing and/or faxing their COCCs on one or more occasions." (Exh. 687, p. 2813.)

c. Ms. Berkel admitted that PacifiCare had incorrectly closed claims based on lack of a COCC "even though a COCC had been received." (RT 9914:3-18 (Berkel).)

d. In October 2006, "Oregon, Washington and California regulators (independently) investigate our processes around COCCs and linking that to pre-existing condition type claims denied for lack of information." (Exh. 5265, pp. 1946-1947.)

e. Around October 2006, CDI began receiving an influx of consumer complaints about PacifiCare, most concerning the company's handling of COCCs. Consumers complained that, although PacifiCare had already received their

COCCs, the insurer was still denying claims on pre-existing conditions grounds and requesting that consumers resubmit evidence of prior coverage. (RT 58:14-59:2; 62:14-24 (Smith); RT 352:11-22 (Masters); Exh. 1041, p. 3269 [Drago 2:36 p.m.]; Exh. 702, p. 5475 [Hill 9:47 a.m.].) Some of these members also reported that prior claims had been paid once they submitted a COCC, but subsequent claims for the same treatment were being denied. (Exh. 5003; RT 52:22-53:12; 58:14-59:2; 62:14-24; 102:21-103:5 (Smith).)

f. Investigation of these complaints revealed that PacifiCare persisted in requesting COCCs after they had been received. (Exh. 22, p. 9513; Exh. 41, p. 9455; Exh. 76; Exh. 166, p. 1506; Exh. 182, p. 2815; Exh. 5004, p. 7576.)

g. When Ms. Smith raised this issue with PacifiCare in October or November 2006, the company confirmed that it had been receiving complaints on the COCC issue from members. (Exh. 5009; Exh. 562, p. 1168.)

256. In January 2007 Ms. Smith wrote a letter to PacifiCare requesting a comprehensive corrective action plan, including review of the processes for handling incoming COCCs and whether the certificates were accessible to the staff who needed them. (Exh. 5004, pp. 7576-7577.)

257. In March 2007, six weeks after receiving this request for comprehensive corrective action, PacifiCare convened a workgroup to examine the "current process [of] managing COCCs across . . . departments" and to begin developing "a process to keep the COCC on file for the duration of the insured's coverage with the plan." (Exh. 687, p. 2813.)

258. In that January 2007 letter, CDI also requested that PacifiCare review "all denials made in 2006 related to the non-receipt of a certificate of creditable coverage." (Exh. 5004, p. 7577.)

259. In response to this request, PacifiCare reported to CDI in June 2007 that the company identified 1,799 claims that it had denied in 2006 due to its failure to properly process COCCs. (Exh. 5314, p. 7378 [number 5]; Exh. 5016; RT 452:16-24 (Smith).)

260. The company issued additional payment for 689 of these claims but contended that no additional payment was owed for the remaining 1,110 claims. (Exh. 103; Exh. 5016.)

a. The additional payments totaled $765,157. (Exh. 5015, p. 7765 [number 2]; RT 250:3-11 (Smith).)

261. PacifiCare failed to fully remediate the remaining 1,110 claims.

a. The 1,110 claims for which no payment was owed included instances in which the payment was applied to the member's deductible. (Exh. 5348, p. 8453 [number 10].)

b. CDI asked PacifiCare to identify other reasons why "no payment is required other than when credit was applied toward the deductible" (Exh. 15, p. 0476 [number 5]) but PacifiCare apparently did not identify any other reasons.

c. CDI repeatedly asked PacifiCare to demonstrate that it had reworked claims that were submitted after the claims for which the payment was now being applied to the deductible. (RT 250:15-252:8 (Smith); Exh. 15, p. 0476.) Ms. Smith explained that "[i]f the deductible would have been met after other claims are also taken into account, then a check should have gone out to the member/consumer to also include interest." (Exh. 5015; see also RT 24965:6-20 (Stead).)

d. In response to these inquiries, PacifiCare asserted that claims received from April 2007 forward would not be adversely affected by the improper denial (Exh. 15, p. 0476), but never showed that it had reprocessed any claims that arose after the reworked claim but prior to the date on which the claim was reworked. (RT 252:9-253:5 (Smith); Exh. 5022, p. 3044.)

262. Several integration mistakes caused or contributed to PacifiCare's failures to maintain COCCs and to these illegal claim denials. (See CDI OB, part IV.A.2.c.)

263. After the acquisition and as late as 2008, PacifiCare did not have in place reasonable standards for handling incoming facsimiles. Documents, such as COCCs, that were sent to PacifiCare by facsimile would often get misrouted or lost.

a. When Cypress staff were laid off, many facsimile machines were left unattended (RT 17695:10-17697:11 (Watson)), even though PacifiCare knew that it received claim dependent correspondence, such as COCCs by facsimile. (RT 14322:25-14323:17 (Murray).)

b. As a result, PacifiCare members repeatedly faxed COCCs and were told that they were "never received." (Exh. 132, p. 4967; Exh. 348, p. 0678.)

c. Because Customer Service personnel were "not trained on how to route correctly though IDT," documents, such as COCCs, that were faxed to Customer Service may not have been routed appropriately and "would go unaddressed." (Exh. 289, p. 6599; RT 2565:13-2566:5; 2573:11-19 (Sing).)

d. PacifiCare continued to observe problems handling documents arriving by fax throughout 2007 and into 2008. The concern that "faxes go to [a] black hole" was a "common theme" in 2007. (Exh. 795, p. 2072.)

e. Claims submitted through customer service fax lines were lost in 2008. (Exh. 351.)

f. As of the time of this hearing, PacifiCare did not have a consistent method for handling incoming faxes. (RT 3177:14-3178:14 (Murray).)

264. The wrongful denial of claims was caused by integration mistakes in outsourcing document routing and storage functions to Lason. These problems began in mid-2006, when such functions were outsourced, and persisted throughout 2007 and into 2008. (See CDI OB, part IV.2.c.)

a. Ms. Berkel admitted that the company "had issues with certificate of credi[ta]ble coverage use pre-August 2006 when we started using Lason and DocDNA. We also have some issues with the use of Lason and DocDNA." (RT 11250:14-18 (Berkel).)

b. The Lason document routing system implemented in July 2006 made it difficult to properly route COCCs received by mail.

c. To properly categorize a COCC, a Lason worker would have to go through several steps and make many difficult determinations about the document that are not apparent from the face of the document. (Exh. 5445; see CDI OB, part IV.2.c.)

d. Mr. Murray, the PacifiCare employee who designed the routing instructions provided to Lason, acknowledged that they were "fragmented" and "complex." (RT 14354:10-17; Exh. 373, p. 0560 ["Lason doc typing business rules are fragmented and complex."].)

e. When Mr. Murray testified at the hearing, he attempted to use the process he had designed to categorize a document, and he made several mistakes. (RT 14371:2-7; 14372:1-7 ["I'm sorry. The flow chart is backwards. The 'without' is the one that refers to the 3 grouping. Sorry about that. I helped in preparing this, so it's my fault."]; 14375:2-9 ["I think I corrected you incorrectly. . . . The original document was correct."].)

f. PacifiCare also admitted that its DocDNA queues and inventory, where documents like COCCs were stored before being processed, were "poorly managed." (Exh. 342, p. 8514.)

g. It sometimes took weeks for a document to reach its destination, with thousands of documents languishing inexplicably in DocDNA queues for over a month. (Exh. 361; Exh. 526, p. 2770; Exh. 666, p. 1103 [Berkel 8:47 p.m.].)

h. While COCCs were in DocDNA queues waiting to be processed, there was no way to search for them (RT 9823:22-9824:15 (Berkel)), a circumstance that Ms. Berkel called "ridiculous" and "an integration mistake" (RT 9825:5-8; Exh. 709 ["Of course, it is ridiculous to me that we route documents through a tool with no way to search for them. This was an integration mistake."]).

i. The cost of making documents searchable within DocDNA was only $40,000 (Exh. 709 [Nakashoji 4:18 p.m.]), but this improvement was initially rejected because "it isn't in the budget." (Exh. 632, p. 9282.)

j. If a member, in appealing a claim denial, notified the company that he or she had already submitted a COCC, the staff would be unable to search for the COCC in DocDNA to confirm that the COCC had been received. (RT 8089:7-8090:17 (Berkel); RT 6371:15-6372:22 (Vonderhaar).)

a. This contributed to PacifiCare instructing members to re-send COCCs multiple times. (RT 8093:12-8097:6 (Berkel); RT 6371:15-6372:22 (Vonderhaar).)

265. PacifiCare failed to adopt reasonable standards for long term storage, indexing, and retrieval of COCCs, which also contributed to incorrect claim denials. (See CDI OB, part IV.A.2.c.)

a. Until mid-2007, Lason was not consistently indexing documents by member ID number in FileNet; accordingly, many COCCs continued to be irretrievable after receipt. (Exh. 574; Exh. 342, p. 8514; Exh. 355, p. 8503; Exh. 365, p. 6872; RT 6353:7-14 (Vonderhaar).)

b. The maintenance of hard copy or imaged COCCs in a retrievable manner is important when an insurer fails, as PacifiCare systemically did here, to update its claim system to reflect receipt of the evidence of creditable coverage.

266. Improper claim denials related to the failure to process and store COCCs can cause significant harm. These denials create the risk that a member will be denied medical care by a frustrated provider or will avoid seeking medical care because he or she cannot afford to pay. (Exh. 1184, p. 18:1-16.)

267. The members most likely to experience such a claim denial are those with chronic health problems, because they have been treated for the same condition within the six months prior to their effective date. These consumers are particularly vulnerable to denial or postponement of medical care. (Exh. 1184, p. 18:16-18.)

268. Consumers felt anxious about the "threat of financial responsibility" for expensive medical procedures that PacifiCare was refusing to compensate providers for. (RT 352:11-353:1 (Masters); RT 1024:13-17; 1041:6-20 (Ms. W.).)

269. The total payment PacifiCare made for the claims denied as a result of its mishandling of COCCs amounted to approximately $765,157. (Exh. 5015, p. 7765; RT 250:3-11 (Smith).) This represents over $1,000 per claim, a significant sum and one that would burden the average California family. (Exh. 1184, p. 27:22-26.)

270. The harm caused by PacifiCare's failure to properly process claims for which it had received a COCC was aggravated by the company's inadequate customer service.

a. PacifiCare's own employees described the company's customer service as "horrible" and "incompetent." (Exh. 678, pp. 2838 ["horrible"], 2917 ["incompetent"].)

b. As United senior office Mr. Wichmann described PacifiCare's service in 2007: "In two words: We stink." (Exh. 945, p. 1059 [Wichmann 12:31 p.m.].) He further complained that the company needed to "remediate PHS service which is a complete mess due to a poor operational integration." (Exh. 945, p. 1059 [Wichmann 12:31 p.m.].)

c. Consumers who contacted PacifiCare to inquire about COCCs that they had already sent and that the company had lost encountered wait times of up to an hour and a half, and when they did finally get a hold of a PacifiCare representative they were often given inaccurate information and treated with "outright rudeness." (Exh. 1065, p. 1102, ¶ 5 ["outright rudeness"]; Exh. 287, p. 6168 [incorrect information]; Exh. 702; Exh. 717, p. 5404; Exh. 678, pp. 2771, 2797, 2801, 2805, 2831, 2836, 2839, 2848, 2855, 2864, 2871, 2876; 2882, 2891, 2894 [1.5 hour wait], 2912, 2917; 3028, 3071; RT 1726:2-1727:20 (Mr. R); RT 3378:21-3379:4 (Sing).)

271. Consumers who sought to resolve claim denials by telephone were often unsuccessful in obtaining resolution. PacifiCare failed to respond to telephonic inquiries and complaints despite repeated efforts by consumers. (Exh. 289, p. 6599; Exh. 286; Exh. 287, p. 6168; Exh. 1065, p. 1102; RT 2564:24-2565:25 (Sing); RT 2674:15-21(K. Griffin); RT 1727:21-1728:7 (Mr. R.).)

2. Number of Acts in Violation

272. PacifiCare has identified 1,799 claims affected by its failure to adopt and implement procedures for maintaining COCCs. (Exh. 5314, p. 7378 [number 5]; Exh. 5016; RT 452:16-24 (Smith).)

273. Of those, 689 required additional payment. (Exh. 103; Exh. 5016.)

3. Determination of Penalty

274. The improper denial of claims when consumers have submitted evidence of creditable coverage is very serious because it can cause denial or postponement of medical care and therefore raises the risk of bodily injury or degradation of health. (Exh. 1184, p. 18:11-18.)

275. Based the severity of the violation, and before considering the specific evidence of PacifiCare's violations, CDI Deputy Commissioner Tony Cignarale recommended placing this violation at 65% of the range from zero to $10,000, or at $6,500 per act in violation of section 790.03, for denials for which the company actually owed reimbursement, and 50% of the range from zero to $10,000, or $5,000 per act in violation, for denials for which the amount applied to the member's deductible. (Exh. 1184, pp. 18:19-19:3.)

276. Evidence was presented of mitigation or aggravation pertinent to five of the factors enumerated in Regulation 2695.12, subdivision (a) with respect to the COCC violations. (Exh. 1184, pp. 26:1-28:23.)

a. The evidence that PacifiCare undertook remedial measures (Reg. 2695.12, subd. (a)(8)) is a slightly mitigating factor, as PacifiCare eventually remediated the Lason problems that contributed to the violations, although the company still has not established a consistent practice for handling faxes. (Exh. 1184, p. 27:5-10.)

b. The harm that flowed from these violations was more extensive than in the typical violation (Reg. 2695.12, subd. (a)(10)) because PacifiCare's inadequate customer service increased member confusion and because the inability to

locate COCCs in DocDNA resulted in members spending considerable time and effort mailing or faxing multiple copies of their COCCs. (Exh. 1184, p. 27:27-28.)

c. PacifiCare did not attempt in good faith to comply with the law (Reg. 2695.12, subd. (a)(11)). The design of the DocDNA process, and the complex and opaque instructions for routing COCCs, made it inevitable that documents would not be properly routed. The lack of oversight of the DocDNA queues made it foreseeable that misrouted COCCs would not find their way to the proper location. The lack of oversight of the indexing function greatly increased the likelihood of errors that would make it difficult to retrieve COCCs. Moreover, the company resisted implementing cost-effective solutions to known process defects because of artificial budget constraints. (Exh. 1184, p. 28:4-12.)

d. The 1,799 claims denied because of mishandling of COCCs during 2006 is an unusually high frequency (Reg. 2695.12, subd. (a)(12)) and the detriment to the public was severe. This is a slightly aggravating factor. (Exh. 1184, p. 28:13-16.)

e. PacifiCare was aware of facts that apprised it of the violations in late 2006 (Reg. 2695.12, subd. (a)(13)) but failed to establish appropriate standards for handling COCCs until 2008. (Exh. 1184, p. 28:17-23.)

f. There was no evidence of mitigating or aggravating circumstances from extraordinary circumstances surrounding these violations (Reg. 2695.12, subd. (a)(1); see Reg. 2695.2, subd. (e)), or from PacifiCare's prior compliance record (Reg. 2695.12, subd. (a)(9).) (Exh. 1184, pp. 26:4-7, 27:11-19.)

g. Although claims involving pre-existing conditions are complex (Reg. 2695.12, subd. (a)(3)), the violations in this case were unrelated to the claim processing challenges posed by those complexities, so this factor is neither mitigating nor aggravating. (Exh. 1184, p. 26:22-26.)

h. The factors enumerated in subdivisions (a)(2), (a)(4), (a)(5), and (a)(6) do not apply to the claims at issue here.

277. Taken together, the evidence of PacifiCare's violations are significantly aggravating and justify a 10% upward adjustment to the unit-penalty for this category, resulting in $7,150 per act in violation for the 689 improper denials for which money was owed the provider, and $5,500 per act in violation for the 1,110 improper denials for which the full allowed amount was applied to the deductible. (Exh. 1184, p. 28:24-29:2.)

278. The aggregate penalty for this category is $11,031,350. (Exh. 1184, p. 29:2.)

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

1. PacifiCare's Violations of Law

279. From around January 2004 until December 2006, PacifiCare applied a 12-month pre-existing condition exclusionary period to group health claims when the law permits only a 6-month period (§ 10198.7, subd. (a)). (RT 8906:1-15; 9216:15-9217:14 (Monk); Exh. 5299, pp. 7549, 7559.)

280. PacifiCare contends that the inclusion of a 12-month period in the group policy was caused by the company's product filer making "a mistake" in creating the certificate of insurance for the large group plan. (RT 8906:16-20; 9222:1-7 (Monk).) That does not excuse the violations of law that occurred here.

281. Nancy Monk testified that the certificate was submitted to CDI, which authorized use of the certificate. (RT 9217:6-11 (Monk).) That does not excuse the violations of law that occurred here.

282. PacifiCare does not contend that the authorization by CDI immunizes the company from violations of law arising from the use of the improper certificate. (RT 9218:4-9219:2 (Monk).)

283. PacifiCare did not have adequate controls in place to prevent or detect errors in its policies.

a. PacifiCare does not require product filing staff to submit their products to a control person within the company for verification, either before or after submission to the approving regulator. (RT 9223:12-25; 9224:14-9225:8 (Monk).)

284. PacifiCare claims examiners applied this 12-month exclusionary period to deny claims on the basis of pre-existing conditions beyond the 6-month period permitted by law. (RT 9216:23-9217:5; 9227:25-9228:22 (Monk).) These claims examiners had not been adequately trained to determine that they were illegally denying claims beyond the legally permissible pre-existing condition exclusionary period.

285. CDI contacted PacifiCare in late 2006 to discuss consumer complaints that PacifiCare was improperly denying claims on the basis of pre-existing conditions when consumers had submitted COCCs. In a follow up phone call, PacifiCare admitted to CDI that the company was applying an improper 12-month exclusionary period. (RT 63:20-64:10 (Smith).)

286. In December 2006, PacifiCare updated RIMS to reflect the 6-month exclusionary period and trained its claims examiners on the proper application of pre-existing conditions provisions. (Exh. 6, p. 7567.)

287. In March 2007 PacifiCare amended its group plan to reflect the 6-month exclusionary period. (Exh. 740, p. 1405; Exh. 11, pp. 7550-7551.) This three-month delay to correct a known error on its group plans that was causing claims to be illegally denied is unreasonable.

288. In the Fall of 2006, CDI demanded that PacifiCare reprocess these illegally denied claims and pay to claimants any additional amounts owed. (RT 10225:1-12 (Berkel).)

289. PacifiCare didn't complete this rework project until April 2007. (RT 10225:8-12 (Berkel).) This delay in remediating these illegally denied claims is unreasonable.

290. PacifiCare reported that it had reworked 3,862 claims that it had illegally denied in 2006 based on pre-existing conditions grounds outside the 6-month period. (Exh. 354, p. 7184, line 20; RT 3460:11-23 (Norket).) PacifiCare determined that it owed

additional payment and interest to claimants for 3,019 of these claims. (Exh. 740, pp. 1405-1406; Exh. 601, p. 9162; RT 6928:20-62929:6 (Vonderhaar); RT 10225:8-12 (Berkel).)

291. PacifiCare knew that the illegal exclusionary period had been in effect since early 2004, but failed to reprocess the wrongly denied claims adjudicated in 2004 or 2005. (Exh. 354, p. 7184; Exh. 740, p. 1405; RT 8910:16-20 (Monk); RT 10225:5-19 (Berkel).) That failure to remediate claim denials that PacifiCare knew were illegal is unreasonable.

a. Ms. Berkel acknowledged that the company should have remediated these 2004 and 2005 claims earlier. (RT 10025:1-19 (Berkel).)

292. During the 2007 MCE, CDI discovered that PacifiCare had failed to reprocess these 2004 and 2005 claims. (RT 10225:13-19 (Berkel).)

293. PacifiCare reprocessed these claims in February 2008, three to four years after they had initially been denied. (Exh. 740, p. 1405; RT 10225:13-19 (Berkel).)

294. The exact number of wrongly denied claims from 2004 and 2005 is unknown, but PacifiCare identified 626 claims for which payment of approximately $100,000 was owed. (Exh. 601, pp. 9161- 9162; Exh. 740, p. 1406; RT 6930:5-10 (Vonderhaar).)

295. PacifiCare's practice of denying claims for pre-existing conditions beyond the legally permissible 6-month period affected at least 2,020 PLHIC members. (Exh. 356.)

296. The number of members whose deductibles should have been credited and should have had subsequent claims readjusted is unknown.

297. The 2007 MCE revealed further problems with PacifiCare's application of the pre-existing condition exclusionary period. (See CDI OB, part IV.B.2.b.)

298. The company admitted during the MCE that it did not track hire dates, which "prevent[ed] the accurate determination of the pre-existing waiting period." (Exh. 118, pp. 3423-3424; RT 6930:22-6931:1 (Vonderhaar).)

299. Ms. Monk testified that the company was only "partially maintaining date of hire" information. (RT 9233:8-15.)

300. CDI's findings and PacifiCare's admissions reflect serious problems with the company's processes for processing pre-existing condition exclusionary periods.

301. These illegally denied claims were attributable to PacifiCare's decision to outsource processing of most PPO claims to MedPlans following the acquisition.

302. Following the acquisition, United and PacifiCare laid off Cypress claims staff and transferred their work to MedPlans and other "lower cost vendors." (Exh. 550, p. 6321; RT 6188:16-24; 6193:19-6194:10; 6197:4-8; 6216:15-22 (Vonderhaar).)

303. By the end of 2006, PacifiCare had transferred to MedPlans most of its claims, including "extremely complicated" claims such as those involving the application of pre-existing condition exclusions. (RT 6850:11-12 (Vonderhaar); Exh. 740, p. 1410.)

304. PacifiCare transferred work to MedPlans even though the company was dissatisfied with MedPlans's performance.

a. In October 2006, for instance, a PacifiCare employee complained that MedPlans's quality levels at the time were "really a cause for termination." (Exh. 1032.)

b. In September 2007 meeting with MedPlans, PacifiCare representatives again complained about the vendor's performance, lamenting that the "same conversations have been had over the past two or three years" (Exh. 560, p. 4878) but "[s]imilar errors keep repeating" (Exh. 560, p. 4879).

c. PacifiCare was understandably concerned that MedPlans was paying its processors on a per-claim basis — which PacifiCare itself complained created an incentive for them to "take the 'easy way out' and deny instead of process" claims so they could get paid more. (Exh. 560, pp. 4878-4879; RT 6227:15-6228:7 (Vonderhaar).) But it failed to insist that MedPlans change its payment structure. (RT 6219:18-23; 6227:5-14 (Vonderhaar).)

305. PacifiCare's accuracy audits — initiated as part of the corrective actions promised to CDI (Exh. 740, p. 1409; RT 10234:9-18 (Berkel)) — revealed continued problems with processing pre-existing condition claims, largely attributable to MedPlans's failures.

a. A January 2008 report, for instance, found that "[i]ssues identified were MedPlans' examiners," that its examiners were continuing to use the incorrect pre-existing denial codes, and that MedPlans had not applied PLHIC's training correctly. (Exh. 355, p. 8498; RT 3467:8-14 (Norket); RT 10234:9-18 (Berkel).)

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

307. PacifiCare did not take seriously the harm it was causing by illegally denying claims, and it refused to take measures to prevent claims from being illegally denied based on pre-existing condition exclusions.

a. Given PacifiCare's admitted inability to correctly process these claims, CDI made a request in the first half of 2008 that the company cease applying the pre-existing condition exclusionary period for certain members until it could process those claims appropriately. (Exh. 742; RT 10241:9-18 (Berkel).)

b. The company estimated that remedial measures would cost it roughly $800,000 (Exh. 808), and ultimately refused to implement them. (RT 10245:22-23 (Berkel).)

308. Although PacifiCare claimed to be taking remedial measures in 2008, those measures were largely ineffective.

309. The company's April 2008 audit results revealed that PacifiCare's error rate for processing pre-existing condition denials continued to be greater than 10% (Exh. 741, pp. 6725-6726; RT 10239:12-14 (Berkel)) — the same error rate as in January 2008 (Exh. 355, p. 8498).

310. In July 2008, PacifiCare reworked 3,030 PLHIC claims that it incorrectly denied between October 2006 and March 2008 on pre-existing condition exclusion grounds.

It owed additional payment and interest totaling $147,414 for 826 of these claims. (Exh. 601, pp. 9161-9162; RT 6930:5-10 (Vonderhaar).)

2. Number of Acts in Violation

311. In 2006, PacifiCare denied 3,862 group claims more than 6 months after the members' effective coverage date in violation of section 10198.7, subdivision (a). (Exh. 354, p. 7184; Exh. 740, pp. 1405-1406; RT 8910:16-20 (Monk); RT 10225:8-12 (Berkel).)

312. PacifiCare has also admitted that it committed at least 1,452 additional acts in violation related to improper application of the pre-existing condition provisions of its policies between 2004 and 2008. (Exh. 601, p. 9162 [626 claims illegally denied in 2004 and 2005, 826 claims illegally denied in 2006-2008 based on additional 3030 project].)

313. This action will award penalties only for the 3,862 claims denied in 2006 as a result of PacifiCare's improper application of a 12-month exclusionary policy.

314. The facts of these additional acts in violation are relevant to the penalties imposed for the 3,862 violations of law at issue in this action.

315. These additional acts in violation reflect PacifiCare's failure to fully and promptly remediate its known violations of law.

3. Determination of Penalty

316. Improper claim denials based on application of an illegal pre-existing condition exclusionary period are very serious violations. (Exh. 1184, p. 29:24-30:4.)

317. Based solely on the severity of the violation, and before considering the specific evidence of PacifiCare's violations, Mr. Cignarale recommended placing this violation at 65% of the penalty range set forth in section 790.035, or at $3,250 for each non-willful act in violation for denials where money was owed the provider. For violations where no money was owed, Mr. Cignarale recommended a starting point at 50% of that range, or $2,500 for each non-willful act in violation (Exh. 1184, pp. 29:26-30:9.)

318. There was evidence presented of mitigation or aggravation relevant to the factors enumerated in Regulation 2695.12, subdivision (a).

a. Adjudication of pre-existing conditions claims is complex (Reg. 2695.12, subd. (a)(3)), but the violations charged here were not caused by the inherent complexity of adjudicating such claims. This factor is therefore neither mitigating nor aggravating. (Exh. 1184, p. 36:11-13.)

b. There is insufficient evidence to assess the relative frequency of the violations (Reg. 2695.12, subd. (a)(7)) as PacifiCare self-identified, in part, the number of violations and CDI did not examine the relevant body of claims. (Exh. 1184, p. 36:14-16.) This factor is neither mitigating nor aggravating.

c. The company undertook some remedial measures (Reg. 2695.12, subd. (a)(8)), including revising the policy and reprocessing the incorrectly denied claims. These remedial measures constitute mitigating circumstances, despite the company's reluctance to adopt further measures to address deficiencies in its processing of pre-existing condition claims that were identified in the MCE. (Exh. 1184, p. 36:17-24.)

d. The company has admitted to at least 626 violations in 2004 and 2006, previous to the violations charged here. This is evidence in aggravation. (Reg. 2695.12, subd. (a)(9).)

e. There is evidence that the harm occasioned by these violations was greater than that usually associated with pre-existing condition denials ((Reg. 2695.12, subd. (a)(10)). PacifiCare committed an unknown number of additional violations where the amount of the improperly denied claim was later applied to the member's deductible. Although the company has not been charged with violations in connection with issuing a false and misleading policy, the 12-month exclusionary period in the policy form may have dissuaded members from seeking medical care. (Exh. 1184, p. 37:3-10.) This is an aggravating factor.

f. Mr. Cignarale credited PacifiCare with attempting in good faith to apply the proper pre-existing condition exclusionary period. (Reg. 2695.12, subd. (a)(11).) (Exh. 1184, p. 37:11-20.) This is a mitigating factor.

g. The violations affected a large number of members over a period of two years, and the significant the detriment to the public, are factors in aggravation. (Reg. 2695.12, subd. (a)(12)) (Exh. 1184, p. 38:1-4.)

h. The company's failure to detect the error in the form policy for two years (Reg. 2695.12, subd. (a)(13)), is a slight aggravating factor. Insurers are obligated to train their claim examiners on the appropriate exclusionary period, but apparently none of PacifiCare's examiners noticed that an illegal exclusionary period was being applied. However, as CDI also failed to ascertain the illegality of the policy, this factor is less aggravating than it would otherwise be. (Exh. 1184, p. 38:6-11.)

i. The factors enumerated in subdivisions (a)(2), (a)(4), (a)(5), and (a)(6) do not apply to the claims at issue here.

j. The filing of an illegal form policy, and CDI's authorization of that policy, do not constitute "extraordinary circumstances" (Reg. 2695.12, subd. (a)) as that term is defined by the Regulations. The filing of policy with an improper exclusionary period was neither outside of PacifiCare's control nor did it "severely and materially affect the licensee's ability to conduct normal business operations." (Reg. 2695.2, subd. (e).)

319. On the basis of the evidence presented to Mr. Cignarale, he concluded that PacifiCare's violations relating to use of an improper 12-month exclusionary period was mitigating and warranted a 50% downward adjustment of the unit-penalty. The unit penalty was reduced from $3,250 to $1,625 per act in violation for claims where payment was owed, and from $2,500 to $1,250 per act in violation for claims where no payment was owed.

320. The existence of a large number of admitted but uncharged violations — which was not considered by Mr. Cignarale — warrant departure from his recommendation.

321. PacifiCare has admitted to an additional 826 acts in violation of the laws governing pre-existing condition provisions, which are not being charged here. The existence and circumstances of these uncharged violations are aggravating factors. (E.g., *Grim v. State Bar* (1991) 53 Cal.3d 21, 33-34; *Ralph Williams Ford v. New Car Dealers Policy & Appeals Bd*. (1973) 30 Cal.App.3d 494, 499-500; see RT 10450:7-22.)

a. PacifiCare investigated the laws governing pre-existing conditions exclusionary periods in late 2005. (RT 63:20-64:10 (Smith).) At that time, the company should have realized the necessity of tracking member's hire dates to properly measure the beginning of the exclusionary period. Yet it denied claims without this information for many years. (Exh. 118, pp. 3423-3424; Exh. 740, p. 1405; RT 6930:22-6931:1 (Vonderhaar).)

b. PacifiCare entrusted adjudication of its "extremely complicated" pre-existing condition claims (RT 6850:11-12 (Vonderhaar)) to MedPlans, a vendor whose quality levels were so low as to be "cause for termination" (Exh. 1032). This decision is evidence of bad faith because it created an unnecessary risk of erroneous claim denials.

c. The company considered transferring this "complex work" back to its own employees in light of the compliance concerns expressed by CDI, but it did not do so. (Exh. 560, p. 4878.)

d. PacifiCare did not audit MedPlans' performance on claims denied for pre-existing conditions until early 2008, when requested to do so by CDI. (Exh. 740, p. 1409; RT 10234:9-18 (Berkel).)

e. PacifiCare recognized that MedPlans' piece-rate payment structure created an incentive for improper denials, but did not require a more rational wage scheme for PacifiCare claims. (Exh. 560, pp. 4878-4879; RT 6233:25-6234:3 (Vonderhaar).

f. PacifiCare's audit results in both January and April of 2008 revealed a high percentage of erroneously denied claims by MedPlans's staff based on pre-

existing condition grounds. (Exh. 355, p. 8498; Exh. 741, pp. 6725-6726; RT 10239:12-14 (Berkel).) This is evidence of a general business practice of mishandling pre-existing condition claims.

322. The 626 claims illegally denied in 2004 and 2005 also represent aggravating circumstances.

323. PacifiCare's failure to remediate these claims for many years, and only then after CDI demanded it, reflects a lack of remedial measures and bad faith by the company.

324. The existence of these additional uncharged violations, and the aggravating circumstances relevant to them, warrant at least a 10% increase over Mr. Cignarale's adjusted unit-penalty recommendation. A 40% reduction in the unit penalty (rather than 50%) is appropriate after considering the factors related to the charged violations and the existence and circumstances of the additional uncharged violations.

325. This results in a unit-penalty of $1,950 for the 3,019 claim denials for which money was owed, and a $1,500 unit-penalty for the 843 improper claim denials for which no money was owed.

326. The aggregate penalty is $7,151,550 for these 3,862 acts in violation.

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

1. PacifiCare's Violations of Law

327. Section 10123.13, subdivision (a)'s requirement that insurers notify members and providers of their right to request review by CDI and of CDI's contact information became effective on January 1, 2006.

328. All PacifiCare Explanations of Payment ("EOPs") sent to providers throughout 2006 and into mid-2007 failed to contain notice to providers that they may seek review by CDI of claims that the insurer contested or denied. (E.g., Exh. 24, p. 3088.)

329. All PacifiCare EOPs sent to providers in 2006 and into mid-2007 failed to include the address, Internet Web site address, and telephone number of the unit within CDI that performs this review function. (E.g., Exh. 24, p. 3088.)

330. PacifiCare's EOPs during that period informed providers only of their right to submit a provider dispute to PacifiCare. (E.g., Exh. 24, p. 3088.)

331. CDI notified PacifiCare of this failure to include right-to CDI-review language and CDI contact information on its EOPs on February 21, 2007. (Exh. 683, p. 9289.)

332. On March 23, 2007, PacifiCare provided CDI a sample of a revised EOP that contained this required notice of the providers' right to seek review by CDI and of CDI's contact information. (Exh. 11, pp. 7542-7543.)

333. On March 23, 2007, PacifiCare promised to CDI that these language changes that added this required information to the company's EOPs "are in process and will be included on EOBs as of 4/8/07." (Exh. 11, p. 7542 [number 1].)

334. That representation was false.

335. PacifiCare did not implement this statutorily required CDI-review language on its EOPs for group claims until June 15, 2007. (Exh. 118, p. 3415.)

336. Therefore, from January 1, 2006, until June 15, 2007, PacifiCare's EOPs for group claims failed to include notice to providers that they may seek review by CDI of claims that the insurer contested or denied, and failed to include the address, Internet Web site address, and telephone number of the unit within CDI that performs this review function. (Exh. 118, p. 3415.)

337. PacifiCare did not implement this statutorily required CDI-review language on its EOPs for individual claims until November 4, 2007. (Exh. 118, p. 3415; Exh. 823; RT 12527:1-12528:5 (Monk).)

338. Therefore, from January 1, 2006, until November 4, 2007, PacifiCare's EOPs for individual claims failed to include notice to providers that they may seek review by CDI of claims that the insurer contested or denied, and failed to include the address, Internet Web site address, and telephone number of the unit within CDI that performs this review function. (Exh. 118, p. 3415.)

339. PacifiCare has admitted that its failure to include this language violated the law. (See CDI OB, part IV.C.2.a.)

a. In a referral dated August 30, 2007, PacifiCare agreed with CDI's finding that its EOPs failed to include the right to contest a claim with DOI and failed to contain the CDI website. (Exh. 1206, pp. 4272-4273.)

b. In its formal response to CDI's MCE reports, PacifiCare agreed with CDI's finding that the company's EOPs "failed to include required wording in the EOB and Explanation of Payments (EOP) correspondence." (Exh. 118, p. 3415; see also RT 8897:2-7 (Monk).)

340. PacifiCare contends that it believed that its EOPs did not require notification of providers' right to seek review by CDI. It contends that it interpreted that requirement to refer to notification of the provider's right to submit provider disputes to the insurance company.

341. To the extent that PacifiCare might have believed that it was not legally required to include notice of CDI review rights on its EOPs, that belief was unreasonable. (See CDI OB, part IV.C.2.b.)

a. The plain language of the statute makes clear that insurers must provide notice of the right to seek review with CDI.

b. The next sentence after this requirement to notify of the right to CDI-review states that the notice "shall also contain a statement advising the provider of its right to enter into the dispute resolution process described in section 10123.137," which is the insurer's provider dispute process.

c. It is unreasonable to interpret section 10123.13, subdivision (a) to require notification of the right to seek review from the insurance company, followed by in the next sentence, a requirement that insurers advise providers of their right to file a dispute with the insurer, as PacifiCare contends it did.

d. The legislative history of Senate Bill 367 ("SB 367") — which PacifiCare staff reviews (RT 12397:23-12398:12 (Monk)) — makes clear that the reference to "department" in the statute is to the California Department of Insurance. (Exh. 680, p. 2 [number 9]; Exh. 681, p. 2 [number 9].)

e. PacifiCare generates implementation logs when new legislation is enacted for the purpose of setting forth requirements for that law or regulation and actions that the company believes need to be taken to comply. (RT 8893:18-8894:19; 9051:25-9052:3; 12452:11-20 (Monk).)

f. The implementation that PacifiCare generated for SB 367 reflects that certain of the company's regulatory staff understood the term "department" in the statute to refer to CDI: "Notice to provider and insured shall advise them that either may seek review by the Dept. of *Insurance* of a claim that the insurer contested or denied." (Exh. 5316, p. 7528 [last row] (emphasis supplied); RT 9272:8-9273:1 (Monk).)

342. All EOPs that fail to pay the full billed amount are contested or denied claims that must include right-to-CDI review language. (See CDI OB, part IV.C.2.b.)

a. As Ms. Stead testified, a claim that has one or more claim lines paid in full, but another claim line denied, is "considered denied because there are portions of that claim particular services of which benefits have not been made available." (RT 25535:17-25536:2 (Stead).)

b. When an insurer pays less than the full billed amount on a claim, it is contesting or denying that claim, even if the insurer believes that it is properly applying a discounted contract rate agreed to with the provider.

c. It is possible — in PacifiCare's case, likely — that the insurer has incorrectly applied the discounted contract rate, and therefore has incorrectly denied or contested part of the claim.

d. That is why a provider must be informed of their right to seek review from CDI or to file a provider dispute with the insurer whenever the full billed amount is not paid.

e. The requirement that insurers notify claimants of their right to seek CDI review is triggered by whether the "*claimant* believes that all or part of the claim has been wrongfully denied or rejected." (Reg. 2695.7, subd. (b)(3).)

f. PacifiCare's corrected EOPs notify providers that: "If *you feel* that all or part of this claim has been wrongfully denied or rejected, you may have the matter reviewed by the California Department of Insurance at: [contact information for CDI's Consumer Services Division]." (Exh. 11, p. 7543 (emphasis supplied).)

343. PacifiCare unreasonably delayed implementing remedial measures to correct these deficiencies in its EOPs. (See CDI OB, part IV.C.2.b.)

a. CDI notified PacifiCare of its failure to include statutorily language on its EOPs on February 21, 2007. (Exh. 683, p. 9289.)

b. PacifiCare promised that the language changes for the EOPs were "in progress and will be included on EOBs as of 4/8/07." (Exh. 11, p. 7542 [number 1].)

c. PacifiCare failed to issue compliant EOPs on group claims until June 15, 2007. (Exh. 118, p. 3415.)

d. PacifiCare failed to issue compliant EOPs on individual claims until November 4, 2007. (Exh. 118, p. 3415; Exh. 823; RT 12527:1-12528:5 (Monk).)

e. PacifiCare's testimony that it failed to implement compliant EOPs sooner because it was treating the EOP and EOB changes as a "single corrective action project" is not credible. (RT 9304:8-9305:25 (Monk).)

f. As Ms. Monk testified, there was no reason that implementation of compliant EOPs needed to be delayed until revised EOBs were ready to be implemented. (RT 9304:18-9305:10 (Monk).)

g. PacifiCare does not contend that CDI objected to the proposed EOP language that PacifiCare forwarded to it on March 27, 2007. (RT 9304:8-11 (Monk).)

h. Ms. Monk has admitted that "in hindsight, we could have implemented [compliant EOPs] earlier than we did the IMR language." (RT 9305:13-15.)

344. PacifiCare's failure to implement CDI-review language on EOPs for individual claims until November 4, 2007 is inexcusable and evidence of bad faith by the company. (Exh. 118, p. 3415; Exh. 823.)

a. PacifiCare has offered no explanation for this unreasonable delay.

b. Ms. Monk claimed not to be aware of PacifiCare's failure to include CDI-review language on EOPs until November 4, 2007. (RT 12525:22-12526:8 (Monk).)

345. Disseminating EOPs that misrepresented provider appeal rights by omitting CDI-review notification harmed providers. (Exh. 1184, p. 40.)

346. The prompt and accurate payment of claims is of critical importance to providers, but also to patients, insurers, and the overall stability of the health care system. (RT 24237:23-24238:14 (Stead); RT 23231:9-23232:2 (Cignarale); Exh. 1184, p. 40:15-18.)

347. The Legislature, in enacting SB 367, intended to ensure that health care service "be available to Californians without unnecessary administrative procedures, interruptions, or delays." (Legis. Counsel's Dig., Sen. Bill No. 367 (2005-2006 Reg. Sess.) (RON, Exh. H, p. 17).)

348. The notice of the right to CDI review and of CDI's contact information required by section 10123.13, subdivision (a) was intended by the Legislature to "reduce confusion about the identity of the appropriate regulator" and "to assure the public that the law is properly implemented." (Legis. Counsel's Dig., Sen. Bill No. 367 (2005-2006 Reg. Sess.) (RON, Exh. H, p. 17).)

349. The statutory right to have the Department review provider grievances was newly created in 2006. This makes notification of that right in 2006 and 2007, shortly after that right was created, all the more important, but it is likely that many providers would have been unaware of that right.

350. Providers who were aware of the right to seek regulatory review were harmed by absence of this information on PacifiCare's EOPs, because they could not discern which

regulator had jurisdiction over the particular claim. (Exh. 1025, p. 0731; RT 17178:1-24; 17180:23-17182:4 (Wetzel).)

351. The harm occasioned by these violations was exacerbated by PacifiCare's poor customer service during this time.

a. Providers who sought to resolve disputed claims with the company were often unsuccessful in obtaining resolution. PacifiCare failed to respond to telephonic inquiries and complaints despite repeated efforts by providers. (Exh. 289, p. 6599; Exh. 286; Exh. 287, p. 6168; Exh. 1019; RT 2564:24-2565:25 (Sing); RT 2674:15-21 (K. Griffin); RT 2668:14-2669:12 (M. Griffin).)

352. Had proper notice been included on EOPs, many of PacifiCare's incorrect claim denials and mispayments could have been remediated sooner or addressed in a manner less costly to providers.

a. The evidence reflects that when the Department intervened on behalf of complainants, the company resolved those complaints relatively quickly, after failing to act on them for months before the Department interceded. (E.g., Exh. 18; Exh. 21 [provider fought with PacifiCare about incorrectly denied claims for almost a year, PacifiCare reprocessed and paid within a month of appeal to CDI]; see also Exh. 138 [Mr. R's claims illegally denied for five months, paid within weeks of complaint to CDI]; Exh. 246; Exh. 247; Exh. 248; Exh. 5098; RT 1959:1-1965:1 (Masters) [repeated denials, followed by payment after receiving notice of complaint to CDI].)

b. As PacifiCare's expert's own analysis demonstrates, the addition of this notification to PacifiCare's EOPs resulted in a 10% increase in complaints deemed justified being filed against PacifiCare. (Exh. 5621, pp. 35-38; Exh. 5622, p. 15; RT 22110:22-22111:11 (Kessler).)

353. The right to petition government for redress has intrinsic value, whether or not that right is exercised. (RT 21055:24-20156:23 (Kessler); Exh. 1184, p. 40:19-24.)

Depriving PacifiCare members of knowledge of that right is inherently harmful. (Exh. 1184, p. 40:21-24.)

2. Number of Acts in Violation

354. Between February 22, 2007, the day after CDI brought the noncompliant EOPs to PacifiCare's attention, and June 15, 2007, PacifiCare issued at least 462,805 EOPs. (Exh. 549; Exh. 1182; Exh. 1180.) (See CDI OB, part IV.C.3.)

355. Each of these 462,805 EOPS was required to include notice of the providers' right to CDI review and of CDI's contact information, but failed to contain this notice.

356. PacifiCare issued many additional illegal EOPs for individual claims without the CDI review notice, but the number of such EOPs is unknown.

357. PacifiCare also issued likely hundreds of thousands more illegal EOPs between January 1, 2006, when section 10123.13, subdivision (a) took effect, and February 21, 2007, which are not being charged here.

3. Determination of Penalty

358. The failure to provide the required notice of appeal rights in an EOB is a moderately severe violation when compared to other violations of law to which section 790.03 applies. Consistent with its moderate severity, such violations justify a unit-penalty 30% of the maximum under section 790.035, or $3,000 for willful violations.

359. Evidence was presented of aggravation or mitigation pertinent to the factors enumerated in Regulation 2695.12, subdivision (a) with respect to the EOP violations.

a. The fact that every single EOP for group claims issued during the period of February 22, 2007, and June 15, 2007, and every EOP for individual claims issued from February 22, 2007 to November 4, 2007 was noncompliant is an aggravating factor. (Reg. 2695.12, subd. (a)(7).) The same evidence indicated a high frequency of violations for purposes of subdivision (a)(12). (Exh. 1184, p. 48:3-10.)

b. The harm occasioned by these violations (Reg. 2695.12, subd. (a)(10)) was greater than would be encountered in the usual case. The noncompliant EOPs

were issued at the very time of deficiencies in PacifiCare's telephone-inquiry system and provider dispute resolution process, and at a time of an unusually high 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. The fact that the rate of complaints to the Department rose after inclusion of the missing information indicates that its omission is likely to have suppressed the rate of appeals to CDI. (Exh. 1184, pp. 46:26-47:10.)

c. These violations reflect an absence of a good faith attempt to comply with the law, an aggravating factor. (Reg. 2695.12, subd. (a)(11).) The claim that PacifiCare misunderstood the statutory reference to "department" to be to anything other than the Department of Insurance is not credited. Furthermore, that claim would be irrelevant to these violations, which all occurred after CDI had called the company's attention to the noncompliance. (Exh. 1184, pp. 47:11-48:2.)

d. The hundreds of thousands of noncompliant EOPs preceding the period of the acts charged represents a history of previous violations of this kind, which is appropriately considered a slight aggravating factor. (Reg. 2695.12, subd. (a)(9); Exh. 549; Exh. 1184, p. 46:22-25.)

e. There is no evidence of extraordinary circumstances (Reg. 2695.12, subd. (a)(1)) and no evidence that the violations were related to the complexity of the underlying claims (Reg. 2695.12, subd. (a)(3)). (Exh. 1184, p. 46:5-10.)

f. Remedial measures were eventually taken, consisting of the correction to the noncompliant notices (Reg. 2695.12, subd. (a)(8)). (Exh. 1184, p. 46:15-21.) The length of time it took for PacifiCare to correct these failures, however, was an aggravating factor (Reg. 2695.12, subd. (a)(13). (Exh. 1184, p. 48:11-15.)

360. Taking these mostly aggravating circumstances into account, it is reasonable to increase the unit-penalty of 10%, from $3,000 to $3,300. (Exh. 1184, p. 48:17-19.)

361. The Department has proposed an additional adjustment in this and other categories in which there is a very large number of acts in violation. Mr. Cignarale observed that while assessing a uniform penalty for each comparable penalty is ordinarily appropriate, it is not necessarily 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. But where, as with the EOP violations, there are over 400,000 acts in violation, it is not necessarily the case that the regulatory and law-enforcement objectives require the same penalty for the 400,000th identical act as for the first. (Exh. 1184, pp. 48:23-49:5.) He therefore recommended that the unit-penalty be gradually reduced in 50,000-act blocks, with the penalty for each successive block of acts reduced by 50%, subject to four limitations: (1) where victims have been harmed, the punishment for each act should exceed that harm; (2) the penalty for each act be greater than any benefit the company may have realized from committing that act; (3) the aggregate penalty for the category must suffice to deter such violations in the future; and (4) no act should receive a penalty less than a minimum that recognizes the systemic harm from violating the law. (Exh. 1184, p. 49:5-10.) For this category, he proposed that the decline in the unit-penalty level off at $50. This proposal is reasonable and yields unit-penalties appropriate to the violations.

362. The resulting schedule of unit-penalties is as follows:

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	462,805	$50

363. This results in an aggregate penalty for the EOP violations of $332,990,250. (Exh. 1184, p. 49:26-28.) For the 462,805 acts in violation, the average unit penalty is $719.50.

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

1. PacifiCare's Violations of Law

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

365. In 2006 and 2007, PacifiCare's EOBs contained a page titled "Know Your Rights," which purported to describe the insured's rights to challenge PacifiCare's determinations. (E.g., Exh. 23, p. 3093.)

a. This page stated that insureds had the right to appeal to PacifiCare adverse decisions, including decisions regarding medical necessity. It then stated that "the Company offers Standard review levels" and referred insureds to their certificates of insurance for more details. (Exh. 23, p. 3093.)

b. It informed insureds that they "may have other voluntary alternative dispute resolution options, such as mediation" and might have the right to file a civil action under the Employee Retirement Income Security Act ("ERISA"). (Exh. 23, p. 3093.)

366. Nowhere in the EOB, on the "Know Your Rights" page or elsewhere, did PacifiCare advise insureds of their right to seek an IMR.

367. PacifiCare EOBs for group claims omitted this statutorily required language throughout 2006 until June 15, 2007. (Exh. 118, p. 3415.)

368. PacifiCare EOBs for individual claims omitted this language from 2006 until November 4, 2007. (Exh. 118, p. 3415.)

369. The Department informed PacifiCare on a teleconference on March 23, 2007, at the latest, that the company's EOBs unlawfully omitted IMR notification language. (Exh. 13, p. 8208; Exh. 5303, p. 8208; RT 1957:22-1958:15 (Masters).)

370. Mr. Masters testified that when CDI initially brought this omission to PacifiCare's attention at a March 2007 meeting, the company acknowledged that the omission was in error and promised to include the required language in its EOBs. (RT 1957:22-1958:15.)

a. Mr. Masters sent a letter dated March 27 in response to the company's request at that meeting for "a sample of the required Independent Medical Review notification language" for the company to include on its EOBs. (Exh. 5303, p. 8208)

371. During the MCE, PacifiCare also admitted in several instances that its EOBs did not meet the requirements of the law because they failed to include notice of the insured's right to request an IMR. (See CDI OB, part IV.D.2.a.)

a. For example, in a September 14, 2007, referral about a specific member claim, CDI found: "The adjusted EOB does not meet the requirements of CIC § 10123.13(a), CIC § 10169(i)." (Exh. 1205, p. 7639.) PacifiCare responded by agreeing with that finding:

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

b. In an August 30, 2007, referral, CDI posed the question to PacifiCare: "Do you agree the EOB(s) sent to the provider on 9/23/06 did not comply with the requirements of CIC 10123.13(a) or 10169(i)?" (Exh. 1206, p. 4272.) The referral further specified that the EOB was deficient because it "does not include reference to the right to an IMR." (Exh. 1206, p. 4272.) PacifiCare responded to that question "Agree with finding," and it again promised that its corrective action plan would provide changes to the EOB/EOP language to include right to IMR language. (Exh. 1206, p. 4273.)

c. PacifiCare's official response to CDI's MCE reports admitted that "[t]he Company failed to include required wording in the EOB and Explanation of Payments (EOP) correspondence" and represented that the company had implemented a corrective action plan to add the requirement language on its EOBs and EOPs. (Exh. 118, pp. 3415, 3419.)

372. Ms. Monk testified that PacifiCare interpreted section 10169, subdivision (i) as not requiring IMR notification language on EOBs, and that PacifiCare made an intentional decision not to include that language on its EOB. (RT 9257:2-13.)

373. Ms. Monk testified that IMR notification language wasn't added to EOBs at the time section 10169, subdivision (i) took effect because "it wasn't required by the statute" and because "at the point in time that a member receives an EOB, they are not eligible to request an IMR, and notice at that point is potentially confusing." (RT 8860:18-8861:2.)

374. That testimony is not credible.

375. PacifiCare's supposed rationale for not including this language on EOBs is unreasonable.

a. PacifiCare offered no contemporaneous documents supporting its supposed interpretation of section 10169, subdivision (i).

b. Upon CDI's request, PacifiCare belatedly produced the implementation log that PacifiCare generated in connection with Assembly Bill 55 ("AB 55").

(RT 12508:20-12509:10; 12510:12-21; 9056:11-21; 9058:3-14 (Monk); Exh. 819.)

c. PacifiCare implementation logs set forth the company's understanding of a law's requirements and the actions that the company believes need to be taken to comply. (RT 8893:18-8894:19; 9051:25-9052:3; 12452:11-20 (Monk).)

d. There is nothing in that implementation log that reflects that PacifiCare analyzed and determined not to include IMR notification language on its EOBs.

e. The implementation log, produced after Ms. Monk's direct testimony, contradicts Ms. Monk's testimony that one of the reasons the company didn't include IMR language on its EOBs was because "at the point in time that a member receives an EOB, they are not eligible to request an IMR, and notice at that point is potentially confusing." (RT 8860:18-8861:2.)

f. The implementation log reflected that the decision was made to include IMR language "in all pre-service and claims delay, denial or modification letters" (Exh. 819, p. 7674); as Ms. Monk acknowledged on cross, pre-service letters are sent at a time before the member is eligible to request an IMR. (RT 12514:20-12515:16.)

g. Many other documents that PacifiCare includes the IMR notification language on, such as its certificates of coverage and denial letters are sent to insureds before they are eligible for an IMR. (RT 9207:15-9208:15 (Monk).)

376. The intent of the IMR notification requirement in section 10169, subdivision (i) is to inform claimants at several points in the claims adjudication process of their right to request an IMR so they are aware of and can avail themselves of these rights if necessary. (RT 22823:7-12 (Cignarale).)

377. Ms. Monk admitted that section 10169, subdivision (i) requires notification of the right to request an IMR regardless of whether or not the claim was denied based on medical necessity. (RT 9207:15-19; 9208:1-6.)

378. Ms. Monk admitted that section 10169, subdivision (i) requires notification of the right to request an IMR regardless of whether or not the insured has filed an appeal with the company and has exhausted the insurer's appeals process. (RT 9207:20-25; 9208:7-15.)

379. PacifiCare unreasonably delayed in implementing compliant IMR notification language on its EOBs. (See CDI OB, part IV.D.2.b.)

a. It was on notice that its EOBs were missing required IMR language by March 23, 2007, at the latest. (Exh. 5303, p. 8208; RT 1957:22-1958:15 (Masters).)

b. By letter dated March 27, 2007, CDI provided PacifiCare with sample IMR notification language that tracked the requirements of section 10169, subdivision (i), informing insureds of their right to request an IMR from CDI if they believed that health care services had been improperly denied. (Exh. 5303, p. 8208.)

c. That letter also provided PacifiCare with copies of PacifiCare's own existing IMR application form and portions of its certificate of coverage, both of which CDI informed PacifiCare included compliant language. (Exh. 5303, pp. 8208, 8210; RT 9241:21-9242:16 (Monk).)

d. CDI reminded PacifiCare in that letter that "[a]cceptable IMR notification must be included on all denials, appeals, and all copies of the insurer's procedures for resolving appeals and grievances" (Exh. 5303, p. 8208) and further warned the company that "[f]ailure to provide the insureds with their legal rights is a violation of 10169 and could have had a chilling effect on the filing of IMR applications by the insureds currently and in the past" (Exh. 5303, p. 8210).

e. PacifiCare could have immediately added to its EOBs the sample IMR language provided by CDI or copied the compliant language from one of its existing documents. According to Ms. Monk, it would have taken the

company no more than 10 days to begin sending compliant EOBs once PacifiCare had finalized the IMR language to include. (RT 9261:2-7 (Monk).)

f. PacifiCare instead elected to draft entirely new IMR language for its EOBs because it was determined to fit all the "Know Your Rights" material onto a single page to avoid incurring additional costs. (RT 11138:18-11139:14; 11144:16-11145:3 (Smith); Exh. 5311, p. 4405 ["Once I get your feedback, I will then send to our claims department to determine if it all fits on one page . . . ."].)

380. PacifiCare's assertion that CDI was responsible for the company's delay in implementing compliant language in EOBs is rejected. (See CDI OB, parts IV.D.2.b, IV.D.2.c.)

a. The company is bears full responsibility for complying with all laws.

b. CDI was under no obligation to assist PacifiCare in this regard.

c. PacifiCare requested that CDI review and comment on proposed language, and CDI did so "[a]s a courtesy." (RT 11071:25-11072:11 (Smith).)

d. CDI repeatedly informed PacifiCare that it does not approve such language, and was only providing feedback "because they [had] asked us." (RT 11141:10-11142:10 (Smith).)

e. Ms. Monk admitted that she understood that CDI was not under a legal obligation to review and correct PacifiCare's proposed IMR notification. (RT 9239:17-9240:1.)

f. As Ms. Smith testified: "CDI is not in the business of giving compliant language to any carrier . . . Yeah, not the Department's job. We don't do this ever." (RT 11071:17-23.)

g. Ms. Smith also testified: "I have instructed the company on many occasions over the phone almost every time we had conversations that we do not approve language, and we do not give any — any sort of — I guess, the blessing that they were looking for. We had — I had personally told the company we

[were] doing this as a courtesy. We will look at the language — because they asked us. But we certainly do not do that type of — we don't perform that type of function." (RT 11141:19-11142:2.)

h. CDI specifically informed PacifiCare in writing that "[i]t is your company's responsibility to compose IMR notification language that complies with California law." (Exh. 5303, p. 8208.)

i. CDI provided compliant sample language, including from PacifiCare's own existing documents, on March 27, 2007. (Exh. 5303, pp. 8208-8210.)

j. PacifiCare's various versions of the IMR sample language sent to CDI were unreasonably vague and failed to inform the insured that the request for an IMR was to be made to CDI. (E.g., Exh. 5357, p. 0598; Exh. 5307, p. 4392.)

k. Because they failed to include something as basic as information notifying insureds of what agency to file an IMR with, these versions do not represent a good faith effort.

381. PacifiCare's failure to implement IMR notification language on EOBs for individual claims until November 4, 2007 is inexcusable and evidence of bad faith by the company. (Exh. 118, p. 3415.)

a. PacifiCare has offered no explanation for this unreasonable delay.

b. Ms. Monk claimed not to be aware of the fact that individual claim EOBs failed to contain IMR language until November 4, 2007. (RT 12522:6-23; 12524:13-24.)

382. PacifiCare represented to CDI that the version of IMR language it sent to CDI on April 20, 2007, would be implemented and that outgoing EOBs "will contain this language as of April 30, 2007." (Exh. 5357, p. 0597.) That representation was false.

a. PacifiCare never told CDI that it failed to implement that IMR language on that date. (RT 11078:10-11079:24; 11122:1-10; 11143:15-20 (Smith).)

b. As Ms. Smith testified: "We've had several dates of when the company said they would implement. My understanding was that they were implementing

those on those dates and then adding to them at the next implementation date. That was my understanding of what they were doing." (RT 11079:16-21.)

383. The harm from omission of IMR rights from EOBs can be serious.

384. The Legislature, in requiring inclusion of IMR notification language in a broad variety of insurance-related documents, intended to expose members to IMR information at several points in the claims adjudication process — even at times when the member may not be entitled to an IMR — in order to create general awareness of this important right. (RT 22822:25-22823:12 (Cignarale).)

385. This section 10169, subdivision (i) reflects a legislative determination that consumers be made aware IMR rights independent of whether the consumer is presently eligible to receive an IMR.

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

387. Requests for IMR submitted to CDI by members who do not meet the criteria for IMR under section 10169, subdivision (j) are treated as a request for the Department to review the grievance. (§ 10169, subd. (d).) Many of these members have meritorious complaints. By reviewing those IMR requests as complaints, the Department is able to bring about positive outcomes for the members. (Exh. 1184, p. 52:13-18; RT 23356:23-23357:7 (Cignarale).)

388. It is impossible to know how many California consumers who were eligible for IMR and would have requested one if PacifiCare's EOBs had disclosed their right to do so. It is likewise impossible to know how many consumers would have benefited from obtaining an IMR or investigation of their grievance by the Department.

389. PacifiCare's poor customer service exacerbated the harm caused by the violations. (See CDI OB, part IV.D.2.d; see also CDI OB, part IV.A.2.e.)

390. The right to petition government for redress has intrinsic value, and depriving PacifiCare members of knowledge of that right is inherently harmful. (RT 21055:24-20156:23 (Kessler); Exh. 1184, p. 52:19-23.)

2. Number of Acts in Violation

391. Between March 24, 2007, the day after CDI brought the noncompliant EOBs to PacifiCare's attention, and the June 15, 2007, implementation of compliant EOBs for group policies, PacifiCare issued at least 336,085 EOBs for group claims. (Exh. 549; Exh. 1183; Exh 1180.) (See CDI OB, part IV.D.3.)

392. Each of the 336,085 EOBs issued during that period is presumed to have denied at least part of the claimed amount, because PacifiCare rarely pays the full amount billed by providers. (RT 24344:7-11 (Stead).)

393. Each of these 336,085 EOBS was required to provide information concerning the right of an insured to request an IMR but failed to do so.

394. PacifiCare issued many additional illegal EOBs for individual claims without the IMR notice, but the number of such EOBs is unknown.

395. PacifiCare also likely issued millions more illegal EOBs between January 1, 2001, when section 10169, subdivision (i) became effective, and March 23, 2007.

396. As to each of these violations, the company had notice that the omission of IMR language was a violation of law. (RT 24985:11-24986:8 (Stead).)

3. Determination of Penalty

397. The failure to provide the required notice of IMR rights in an EOB is a moderately severe violation when compared to other violations of law to which section 790.03 applies. Consistent with its moderate severity, such violations justify a unit-penalty 35% of the maximum under section 790.035, or $3,500 for willful violations. (Exh. 1184, p. 52:3-28.)

398. Evidence was presented of aggravation or mitigation pertinent to the factors enumerated in Regulation 2695.12, subdivision (a) with respect to the EOB violations.

a. The relative number of claims where the noncomplying facts were found (Reg. 2695.12, subd. (a)(7)) is an aggravating factor, since "every single group claim EOB issued during the period of March 24, 2007, and June 15, 2007, and every individual claim EOB from March 24 to November 4, 2007, was noncompliant." (Exh. 1184, p. 59:16-18.)

b. The presence of previous violations (Reg. 2695.12, subd. (a)(9)), consisting of hundreds of thousands of noncompliant EOBs issued before the first charged violations, is a slightly aggravating factor. (Exh. 1184, pp. 59:25-60:5.)

c. PacifiCare undertook remedial measures to correct its EOBs (Reg. 2695.12, subd. (a)(8)), but that is only a slightly aggravating factor in light of the undue failure to promptly revise the form, even in the interim, while developing the one-page language the company preferred to use in order to reduce costs. (Exh. 1184, p. 59:19-24.)

d. The company showed good faith in attempting to comply (Reg. 2695.12, subd. (a)(11)) by quickly submitting revisions after receiving CDI-staff comments. (Exh. 1184, pp. 60:22-61:6.)

399. In light of these aggravating and mitigating factors, it is reasonable to reduce the unit-penalty for this category of violations from the generic starting point by 35%, to $2,275 per act in violation.

400. Consistent with Mr. Cignarale's recommendation of an adjustment for categories with a very large number of violations, it is appropriate to reduce the unit-penalty by 50% in 50,000-act blocks, not to fall below $50 per act in violation. (See Exh. 1184, p. 62:7-11.) The resulting schedule of unit-penalties is:

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

(Exh. 1184, p. 62:1-19.)

401. This results in an aggregate penalty for the EOB violations of $225,749,563. That yields an average unit-penalty for this category of $671.70 per act in violation.

E. Failure to Timely Pay Claims

1. PacifiCare's Violations of Law

a. **CDI Market Conduct Examination Findings**

402. During the 2007 MCE, CDI investigated PacifiCare's compliance with section 10123.13, subdivision (a)'s requirement that insurers reimburse, contest, or deny claims within 30 working days. (Exh. 107, pp. 4006-4007; Exh. 108, pp. 4758-4759.)

403. PacifiCare initially underreported to CDI the number of claims that the company had paid late during the MCE period. (See CDI OB, part IV.E.2.a.)

a. In an August 18, 2007, referral to PacifiCare, CDI requested that PacifiCare self-report the number of claims paid over 45 calendar days after the receipt of the claim. (Exh. 106, p. 5073.)

b. In response, PacifiCare produced data indicating that during the MCE review period, the company had paid a total of 207 claims late. (Exh. 106, p. 5073.)

404. After CDI noted inconsistencies in those data PacifiCare produced (Exh. 106, p. 5073), PacifiCare produced revised claims data on August 23, 2007 (Exh. 107, p. 4006; Exh. 108, p. 4758).

405. Those revised claims data revealed that PacifiCare had paid 37,238 group claims more than 30 working days after receipt. (Exh. 107, p. 4006; Exh. 108, p. 4758.)

406. PacifiCare's prior claims data submission incorrectly represented the number of late-paid claims.

407. PacifiCare also admitted that the original submission contained incorrect dates. (Exh. 106, p. 5072.)

408. After examining data for individual claims, CDI cited PacifiCare for a total of 42,137 violations for failing to timely reimburse claims. (Exh. 116, p. 1302.)

409. On or about November 9, 2007, CDI transmitted to PacifiCare verified written MCE reports containing these citations. (Exh. 116, p. 1302.) PacifiCare was provided 30 days to make a written submission or rebuttal with respect to any of the matters contained in those examination reports. (Exh. 116, p. 1411.)

410. PacifiCare's December 7, 2007, response letter agreed that 42,137 claims were paid after 30 working days. (Exh. 118, p. 3426.)

b. **CDI's Investigation of Member and Provider Complaints Against PacifiCare**

411. In late 2006, CDI began receiving a large number of member and provider complaints against PacifiCare. (RT 52:22-53:16 (Smith); RT 349:24-350:4; 352:12-353:1 (Masters).) Many of these complaints related to the PacifiCare's late and incorrect claims payments. (RT 351:21-352:2; 352:12-353:1 (Masters).)

a. When CDI receives complaints against an insurer, it will typically inform that insurer and request that the company re-review the issue and send the complainant a response. (RT 355:5-356:8 (Masters).) CDI also requests that the company produce the entire claim file pertaining to the complaint for CDI's review. (RT 355:12-24; 356:9-21 (Masters).)

b. In reviewing complaints, CDI will seek to determine whether the particular complaint has merit and will also perform a full regulatory review of the claim file, citing any noncompliance with the Insurance Code or the Regulations. (RT 356:11:21 (Masters).)

c. If citations are found, CDI will issue a closing violation letter identifying the violations being charged against the company and providing the company with an opportunity to contest those violations. (RT 356:15-357:10 (Masters); e.g., Exh. 37.)

412. With respect to the complaints against PacifiCare received after the acquisition, CDI issued at least 133 closing violation letters. (Exh. 19; Exh. 22; Exh. 29; Exh. 36-102; Exh. 130-131; Exh. 133-134; Exh. 166-223.)

413. In those violation letters, PacifiCare was cited over 200 times for failing to pay claims within 30 working days of receipt. (E.g., Exh. 1209, ¶¶ 2, 3, 9, 14, 18, 28, 29, 30, 32, 33, 35, 36, 37, 42, 45, 46, 47, 48, 49, 50, 52, 53, 54.) (See CDI OB, parts IV.E.2.b; IV.E.3.)

414. The complaints from members and providers reflect serious deficiencies in PacifiCare's claims processing.

415. Those complaints also reflect the harm inflicted on members and providers by PacifiCare's violations.

a. One PacifiCare member, Mr. R, filed a complaint against PacifiCare in December 2006, alleging delays in claims payment and incorrect denials. (Exh. 135, p. 9536 ["We have spent many hours because of their delay tactics. Plus they never respond to our requests for return calls."].)

b. Mr. R had surgeries performed on his eyes in July and August 2006. (RT 1715:13-1716:10 (Mr. R); Exh. 135, pp. 9760, 9763.)

c. Before those surgeries were performed, Mr. R's doctor sought and received pre-approval from PacifiCare. (RT 1716:15-19 (Mr. R).)

d. Mr. R paid for the surgeries out-of-pocket the using his personal Visa credit card; the surgery on the right eye cost $2,245, and left eye surgery cost $1,395. (Exh. 135, pp. 9760, 9763; Exh. 242; RT 1717:7-9; 1720:14-17; 1721:6-15; 1722:3-9 (Mr. R).)

e. In July and August 2006, Mr. R submitted to PacifiCare claims for reimbursement for these two eye surgeries. (Exh. 135, pp. 9886, 9888; RT 1720:20-24; 1722:17-21 (Mr. R).)

f. PacifiCare failed to acknowledge these claims. (RT 1724:8-13; 1724:20-23 (Mr. R).)

g. When Mr. R called PacifiCare to make sure it had received everything and to check the progress on the claims, PacifiCare initially claimed not to have received the claims. (RT 1724:25-1725:12 (Mr. R).)

h. Believing the claims to have been "apparently lost or misfiled" by PacifiCare, Mr. R, therefore, re-submitted the claims three separate times by facsimile. (RT 1723:10-16; 1725:7-12 (Mr. R).)

i. Throughout August 2006, Mr. R called PacifiCare on almost a daily basis regarding these claims. (RT 1726:2-4 (Mr. R).)

j. Mr. R testified that for a long period, PacifiCare's phone lines were busy or no one would pick up the phone; in some instances, the line wouldn't even ring. (RT 1726:10-1727:3; 1727:9-17 (Mr. R).) PacifiCare admitted to Mr. R that it was having problems with their phones and was in the process of switching phone systems. (RT 1726:14-1727:3 (Mr. R).)

k. When Mr. R did reach a customer service representative, he would be given incorrect information about his claims. (RT 1726:4-10 (Mr. R).) Mr. R also asked several times to speak to a supervisor, but no one ever returned his calls. (RT 1727:23-1728:7 (Mr. R).)

l. PacifiCare incorrectly denied Mr. R's claims for multiple different reasons. First, PacifiCare issued an EOB dated 9/14/2006 that denied the claim on the ground that eye exams, glasses, contact lenses and routine eye refractions are not covered. (Exh. 140, p. 9721; RT 1729:10-1730:3; Exh. 243; RT 1733:2-11 (Mr. R).) That denial was wrong.

m. Then, PacifiCare denied a claim by EOB dated 1/13/2007 on the ground that it was ineligible. (Exh. 140, p. 9734; RT 1730:4-20 (Mr. R).) That denial was wrong.

n. Then, PacifiCare denied a claim on the ground that the surgery was done outside the approval dates. (Exh. 243; RT 1733:12-16 (Mr. R).) That denial was wrong.

o. Mr. R filed a complaint with CDI on or about December 21, 2006. (Exh. 135, pp. 9535-9536; RT 1739:20-1740:17 (Mr. R).)

p. Shortly after, on or about December 27, 2006, PacifiCare processed and paid Mr. R's claim for one of his surgeries. (Exh. 140, p. 9725; RT 1741:10-20 (Mr. R).) That claim was submitted in July 2006. (Exh. 140, p. 9725; Exh. 135, p. 9886.)

q. PacifiCare paid a total of $22.60 of interest on that late-paid claim. (Exh. 140, p. 9725; RT 1741:24-1742:2 (Mr. R).) That amount of interest did not compensate Mr. R for the costs he incurred because of PacifiCare's late payment of the claim. (RT 1742:3-17 (Mr. R).)

r. On or about January 15, 2007, PacifiCare processed and paid Mr. R's claim for the other surgery. (Exh. 140, p. 9738; RT 1746:8-21 (Mr. R).) This claim was submitted to PacifiCare in August 2006. (RT 1746:22-1747:1 (Mr. R); Exh. 135, p. 9888.) No interest was paid on this late-paid claim. (Exh. 140, p. 9738; RT 1747:2-5 (Mr. R).)

s. PacifiCare contended that it had not received this claim until January 5, 2007. (Exh. 138, p. 9750; RT 1748:2-8 (Mr. R).) That contention was wrong. Mr. R received denials from PacifiCare for that claim prior to January 5, 2007. (RT 1748:18-1749:6 (Mr. R).)

t. Mr. R testified that his experience with PacifiCare was frustrating. He spent a lot of time and a lot of effort in attempting to get PacifiCare to correctly process his claims. (RT 1738:24-1739:2; 1749:7-15.)

u. Mr. R also incurred interest on his Visa credit card that he had used to pay for the surgeries. (RT 1742:9-14 (Mr. R).) Mr. R also spent money sending facsimiles to PacifiCare to submit and re-submit his claims. (RT 1742:6 (Mr. R).)

v. Dr. Mazer testified that it took PacifiCare approximately six months to pay a particular claim. (RT 3041:7-3042:6 (Mazer); Exh. 330, p. 4.)

w. Dr. Mazer testified that PacifiCare's delay in paying his claim imposed "extremely burdensome" costs on him and his practice. As he testified, the harms of such delays include:

> "the amount of time that has to go into making phone calls, drafting letters, researching claims, pulling claims from three years earlier, my staff's time, my review to decide what action to take, typing up letters, transcribing them, proofing them, mailing them out, the overhead costs are extremely burdensome, not to mention the frustration, not to mention the extreme delay in collecting payment for services properly rendered in good faith, expecting payment, and the damage it does to my ability to deal with a patient, when they have financial issues hanging over their head." (RT 3051:17-3052:2.)

x. Delays in claims payment also can interfere with the physician/patient relationship because the physician may need to seek payment from the patient several months after the service was rendered. (RT 3052:5-8 (Mazer).)

y. Dr. Mazer also testified that his experience with PacifiCare in trying to get a claim paid was "sheer unadulterated frustration." (RT 3036:13.)

416. For several years, PacifiCare systematically failed to correctly pay claims to UCSF in a timely manner, causing harm to that provider group.

a. From 2004 until March 2008, PacifiCare incorrectly paid thousands of claims to the UCSF Medical Group. (Exh. 619; RT 4142:23-4146:22 (Martin).)

b. PacifiCare admitted that it incorrectly paid these claims. (RT 4150:11-20; 4152:15-22 (Martin); Exh. 5157, p. 9585-9586; Exh. 5158, pp. 9574-9575; RT 12612:15-12613:17 (Harvey).)

c. PacifiCare, however, refused to reprocess these claims, as requested by UCSF representative Margaret Martin. (RT 4155:5-4156:11 (Martin).)

d. PacifiCare proposed a lump-sum settlement to resolve these underpaid claims. (RT 4155:5-8 (Martin).)

e. That settlement required UCSF to engage in a time-consuming claim-by-claim reconciliation process with PacifiCare. (Exh. 619, at pp. 1-3, ¶ 3-11; RT 4153:12-4154:17 (Martin).)

f. This settlement had not been reached as of the time Ms. Martin testified on February 22, 2010. (RT 4239:6-24 (Martin).) As a result, these claims were not fully and correctly paid until years after they had been submitted.

417. From 2007 until around March 2008, PacifiCare systematically failed to correctly pay thousands of UCLA claims in a timely manner. (Exh. 613; Exh. 614; Exh. 615; Exh. 616; RT 3791:15-17; 3796:8-16 (Rossie).)

a. PacifiCare resolved those claims by settlement after Mr. Rossie first testified at the hearing on February 11, 2010, years after those UCLA claims were submitted. (RT 7072:17-7073:23; 7119:8-7127:9 (Rossie); RT 11689:22-11692:12 (Lewan).)

b. PacifiCare failed to fully and correctly pay these claims until years after they were submitted.

418. PacifiCare also failed to respond to thousands of UCLA claims from around March 2008 to August 2009. (RT 7063:9-20; 7076:7-21 (Rossie); Exh. 5237; Exh. 5388.)

a. These claims were not processed until after Mr. Rossie first testified on February 11, 2010. (RT 7063:9-20; 7066:22-7067:9 (Rossie); Exh. 5237; Exh. 5388.)

b. These claims were not reimbursed, contested, or denied within 30 working days.

419. As Mr. Cignarale testified, the payment of claims "is, of course, central to the proper functioning of the health insurance system. Failing to timely pay claims can impose significant financial and administrative burdens on claimants." (Exh. 1184, p. 101:10-12.)

420. The testimony of the patient and provider witnesses in this hearing confirm the serious level of harm caused by PacifiCare's failure to timely process claims.

421. Many of these late-paid claims that were uncovered during CDI's investigation of member and provider complaints were paid six or more months after receipt by PacifiCare. (E.g., Exh. 22; Exh. 29; Exh. 53; Exh. 57; Exh. 72; Exh. 75; Exh. 78; Exh. 91; Exh. 94; Exh. 95; Exh. 96; Exh. 101.)

422. Mr. Cignarale concluded that in the case of PacifiCare, "the harm caused by late-paid claims was exacerbated by PacifiCare's failure to promptly respond to inquiries and complaints by both providers and consumers." (Exh. 1184, p. 112:1-2.)

c. **Root Causes of PacifiCare's Violations**

423. PacifiCare's rushed and poorly planned transition of mailroom and routing functions to Lason was a root cause of its failures to pay claims timely. (See CDI OB, part IV.E.2.c.)

a. Specifically, in July 2006, PacifiCare outsourced several "particularly critical" functions to Lason (RT 6316:22-24 (Vonderhaar)), including scanning and routing of claim-related correspondence, data entry of paper claims into RIMS, claim pre-processing functions including manual member eligibility and provider matching, and scanning of secondary documents (correspondence that had been used to process a claim) for storage in PacifiCare's FileNet system. (Exh. 283, p. 3659; Exh. 5046, p. 2236; Exh. 517, p. 1847; RT 3217:19-3218:6; 14290:21-24; 3180:9-3181:25; 3201:22-3202:13; 14308:24-14309:14 (Murray).)

b. PacifiCare provided "fragmented," "complex," and "unclear" document routing instructions to Lason, which led to many errors in categorizing documents and "significant re-routing" between DocDNA queues. (Exh. 373,

p. 0560; Exh. 370, p. 8617; RT 6870:5-6871:5 (Vonderhaar)); RT 2463:14-2464:14 (Norket).)

c. PacifiCare failed to dedicate sufficient resources to manage the documents that needed to be processed. This resulted in "buildups of inventory" of documents that needed to be processed. (RT 13784:1-25; 14319:3-6 (Murray).)

d. The delays in document routing and processing resulted in failures to pay claims promptly. (Exh. 750, p. 7699; Exh. 666, pp. 1103-1104; Exh. 342, p. 8514; RT 8473:8-17; 11249:24-11250:18 (Berkel).)

e. Lason was instructed to sort claims into claims engines based on what post office box the claims had been mailed to. (Exh. 5223; Exh. 5252, p. 6930.) The company knew that sorting based on post office box was not a reliable indicator of whether the claims should be adjudicated on RIMS or NICE because providers bundled their claims and sent them to a single post office box regardless of the line of business. (Exh. 710; RT 6115:21-6116:13 (Vonderhaar).)

424. After these functions were transitioned to Lason, PacifiCare did not equip Lason with sufficient tools to properly sort and route claims. This resulted in claims not being routed to the correct claims engines, and delayed the processing of claims.

a. Prior to outsourcing, the Cypress mailroom staff had access to the claims engines and could look up members to determine eligibility and to determine where to route claims. Access to those claims engines was not provided to Lason staff after the transition. (Exh. 573, p. 2770 [Hinrichs 1:45 p.m.]; Exh. 711; RT 14315:6-19 (Murray).)

b. Throughout 2006 and 2007, PacifiCare did not provide Lason with tools to resolve eligibility matching problems. Lason had no way to "look up individual members and determine into which PHS platform the claims should be keyed." (Exh. 573, p. 2770 [Hinrichs 1:45 p.m.].)

c. When Lason staff couldn't determine eligibility for a claim, the default instruction was to send the claims to NICE. (Exh. 573, p. 2770 [Hinrichs 1:45 p.m.].)

d. PPO claims that were sent to NICE would "reject" when no eligible member could be located on NICE. (RT 6117:14-22; 6352:3-9 (Vonderhaar).)

e. Claims that had errored out from one claims platform would be sent to another platform, and would sometimes "bounce" or "loop" between platforms up to eight or nine times before being adjudicated. (RT 13958:1-13959:5 (Vavra); Exh. 881.)

f. Claims looping was a "very big issue" in late 2007. (Exh. 881 [Vavra 2:45 p.m.].) Out of 120,000 paper claims received for California, Oregon, and Washington each month, "a huge 62%", or 74,000 claims per month, had "match issues" that caused them to fall out of auto-adjudication and into Claims Exchange error queues. Of these, 38,000 could not be automatically matched to an eligible member. (Exh. 554, p. 0310 [Berkel 1:09 p.m.].)

g. The claims looping problem caused PacifiCare to "fail the prompt pay laws of California." (Exh. 554, p. 0310 [Berkel 1:09 p.m.].)

h. For several months after the transition to Lason, the rejected hard copy claims had to be mailed back to PacifiCare offices to resolve why the documents could not be entered, and then mailed back to Lason for a second attempt at data entry. (Exh. 410, p. 7401 [number 7]; Exh. 896.)

i. Many claims were "aged" by several weeks by the time they were corrected and returned to Lason. (Exh. 339, p. 2462; Exh. 366, p. 7266.)

j. Thousands of claims were paid late as a result. (Exh. 571, p. 2532.)

k. Root causes of the "reject" problem included PacifiCare's failure to give Lason proper keying guidelines (Exh. 885; RT 14011:25-14012:15; 17469:22-17470:7 (Vavra)); inadequate instructions on sorting keyable claims from nonkeyable documents (Exh. 885; RT 14016:1-10 (Vavra); and Lason's failure

to make information contained in claim attachments accessible to the Lason data entry staff. (Exh. 885; RT 14014:12-14015:9 (Vavra).)

425. United and PacifiCare refused to invest in resources to remediate the issues with Lason that were causing delays in processing claims.

a. In late 2007, Ms. Berkel proposed giving Lason access to a tool called "FETrain" to resolve claim looping. (Exh. 370, p. 8617; 9850:13-22 (Berkel).)

b. FETrain would allow Lason to perform an eligibility lookup across all United and PacifiCare platforms and, in testing, had significantly improved eligibility matching. (Exh. 573, p. 2770 [Hinrichs 1:45 p.m.].)

c. FETrain was already used by the RMOs supporting legacy United business. (Exh. 573, p. 2770 [Hinrichs 1:45 p.m.].)

d. Enhancing FETrain so that it showed which type of PacifiCare policy a member was enrolled in would have cost roughly $65,000 to implement. (Exh. 554, p. 0310 [Parsons 2:08 p.m.]; Exh. 365, p. 6867; RT 9848:25-9849:3 (Berkel).)

e. The proposal met "resistance" from United's Finance department despite the "relatively low cost and high value associated with this enhancement." (Exh. 554, p. 0310 [Parsons 2:08 p.m.].)

f. FETrain was not implemented for PacifiCare until, by Ms. Vonderhaar's estimate, "late 2008, early 2009." (RT 6118:7-11 (Vonderhaar); Exh. 711.)

426. Many of these late-pay violations could have been prevented had PacifiCare taken adequate time to prepare for the transition to Lason, and had PacifiCare allocated sufficient resources to transitioning these "particularly critical" functions to Lason.

427. PacifiCare's rushed and poorly planned implementation of the EPDE data feed also resulted in delays in paying claims. (See CDI OB, part IV.E.2.)

a. Beginning in June 2006, PacifiCare stopped directly maintaining provider data in RIMS; instead, the company maintained all California PPO provider data in NDB and used the EPDE data feed to update provider demographic and fee

schedule data in RIMS. (Exh. 767, p. 3316; RT 14989:13-20 (Lippincott); RT 7460:9-17 (Berkel).)

b. The company failed to analyze and resolve structural incompatibilities between NDB and RIMS before launching EPDE, despite the many differences in their system architecture. (Exh. 759, p. 6084.)

c. PacifiCare did not sufficiently test EPDE before launching it. (Exh. 759, p. 6084; Exh. 388, p. 4954; Exh. 921; RT 4036:2-4037:20 (Barbati); RT 8231:3-9 (Berkel).)

d. EPDE was implemented before PacifiCare understood the different file structures used in RIMS and NDB for identifying the billing address to which checks were sent. (Exh. 602, p. 1246; RT 10991:8-12 (McFann); RT 15102:1-10 (Lippincott).)

e. One of the results of PacifiCare's failures in implementing EPDE was that the feed activated outdated address and checks were sent to these old addresses. (Exh. 917, p. 6488.)

428. After implementation of EPDE, PacifiCare failed to quickly detect and remediate problems. This failure caused delays in claims payment.

a. PacifiCare knew or should have known that EPDE was changing billing addresses such that provider reimbursement checks were sent to incorrect addresses.

b. Shortly after EPDE was implemented, a provider group began complaining to PacifiCare that "for some reason" the insurer was "sending checks to 1 of 3 previous addresses" despite the fact that the group had "been at the same address for years." Efforts to induce PacifiCare to resolve the problem were "unsuccessful." (Exh. 1021, p. 0280 [Black 3:53 p.m.].)

c. In November 2006, a PacifiCare employee reported multiple instances of changes to providers' billing suffixes. She suggested that a report be run to

identify all the providers affected, but the suggestion was apparently not heeded. (Exh. 495.)

d. In December 2006 and January and February 2007, further evidence surfaced that an EPDE error was changing addresses in RIMS. (Exh. 507, pp. 3923-3924; Exh. 850, p. 8067; Exh. 354, p. 7184 [number 17].)

e. By February 2007, CDI had initiated detailed discussions with PacifiCare regarding complaints about "payments sent to old/outdated addresses." (Exh. 5, p. 0705; Exh. 7.)

f. The company refused to investigate the root cause of returned checks because NDB was the "source of truth," "so regardless of what was previously in RIMS, it's good now." (Exh. 850, pp. 8066-8067 [Rao 2:23 p.m.].)

g. This was an improper basis for declining to investigate further. The company was aware by this time that inaccurate data in NDB had corrupted accurate RIMS data. (RT 15129:15-15130:3 (Lippincott).)

h. As a result of the failure to investigate known instances of checks being sent to the wrong address, the company did not identify the structural defect causing the error until April 2007. (Exh. 917.)

2. Number of Acts in Violation

429. PacifiCare admitted at the hearing that its claims data reflects that the company paid 38,567 claims more than 42 calendar days after receipt. (Exh. 5369, p. 7875; RT 10050:9-10050:14; 11190:16-11190:21 (Berkel).)

430. PacifiCare contended at the hearing that its new data reflect that of these 38,567 late-paid claims, 3,132 were claims that PacifiCare overpaid, 452 were contested claims, and 49 were claims paid under self-directed accounts that PacifiCare argues are not subject to the time requirements of section 10123.13, subdivision (a). (Exh. 5369, p. 7875; Exh. 5252, p. 6937; RT 7640:8-7643:22 (Berkel).)

431. CDI has withdrawn its allegations that these 3,633 claims are acts in violation of section 790.03, subdivisions (h)(2), (h)(3), (h)(4), and (h)(5) and section 10123.13, subdivision (a). (Exh. 1177, ¶ 25.)

432. PacifiCare contended at the hearing that its new data reflects that of these 38,567 late-paid claims, 5,921 are claims that were processed more than 30 working days after receipt, but on which PacifiCare did not owe money because the entire amount owed was applied to the member's deductible. (Exh. 5369, p. 7875; RT 7640:23-7641:4; 10048:1-15; 10053:20-10054:15 (Berkel).)

433. As discussed in the Legal Conclusions, these 5,921 claims do constitute acts in violation of section 790.03, subdivisions (h)(2), (h)(3), (h)(4), and (h)(5) and section 10123.13, subdivision (a).

434. In total, PacifiCare's claims data covering the MCE period reflects that PacifiCare committed at least 34,934 acts in violation of these sections. (Exh. 5369, p. 7875.)

435. Based on PacifiCare's claims data, tens of thousands of those late-paid claims were paid more than a month after the 30-working-day period had elapsed. (Exh. 5190 [Spreadsheet used by PLHIC with Washington]; RT 9595:17-21 (Washington).)

436. There were 239 claims that were processed more than 30 working days after receipt that were uncovered though CDI's investigation of consumer complaints against PacifiCare. In each of those instances, CDI issued a closing violation letter to PacifiCare. (Exh. 22, p. 9512 [3 citations]; Exh. 29, p. 1031 [7 citations]; Exh. 38, p. 4087 [2 citations]; Exh. 41, pp. 9453-9454 [9 citations]; Exh. 46, p. 0979 [2 citations]; Exh. 48, p. 9387 [3 citations]; Exh. 51, p. 0667 [1 citation]; Exh. 53, p. 2883 [6 citations]; Exh. 57, pp. 8684-8685 [8 citations]; Exh. 58, pp. 9942-9943 [5 citations]; Exh. 59, p. 9375 [2 citations]; Exh. 61, p. 9880 [1 citation]; Exh. 65, p. 8535 [1 citation]; Exh. 66, p. 9036 [1 citation]; Exh. 67, p. 9315 [1 citation]; Exh. 69, p. 1449 [1 citation]; Exh. 70 [1 citation]; Exh. 71, p. 8795 [1 citation]; Exh. 72, p. 8878 [1 citation]; Exh. 75, p. 9374 [1 citation]; Exh. 76, p. 8928 [1 citation]; Exh. 78, p. 6139 [2 citations]; Exh. 79, p. 6317 [1 citation]; Exh. 81,

p. 5975 [1 citation]; Exh. 87, p. 7477 [11 citations]; Exh. 88 [1 citation]; Exh. 89, p. 6802 [8 citations]; Exh. 91, p. 2318 [1 citation]; Exh. 92, p. 2610 [1 citation]; Exh. 93, p. 2752 [1 citation]; Exh. 94, p. 9810 [3 citations]; Exh. 95, p. 0056 [8 citations]; Exh. 96 [1 citation]; Exh. 99 [1 citation]; Exh. 101 [1 citation]; Exh. 102, p. 4588 [2 citations]; Exh. 166, p. 1505 [7 citations]; Exh. 171, p. 5347 [1 citation]; Exh. 173, p. 8514 [2 citations]; Exh. 178, p. 1911 [12 citations]; Exh. 179, p. 9892 [6 citations]; Exh. 182, p. 8214 [6 citations]; Exh. 185, p. 4485 [5 citations]; Exh. 189, p. 7722 [7 citations]; Exh. 191, p. 2939 [8 citations]; Exh. 192, p. 2552 [2 citations]; Exh. 195, p. 1000 [2 citations]; Exh. 196, p. 9653 [1 citation]; Exh. 202, p. 9682 [13 citations]; Exh. 203, p. 9632 [8 citations]; Exh. 204, p. 9655 [15 citations]; Exh. 206, p. 9686 [3 citations]; Exh. 209, p. 7064 [16 citations]; Exh. 211, p. 9710 [1 citation]; Exh. 212, p. 9569 [1 citation]; Exh. 213, p. 9665 [9 citations]; Exh. 214, p. 1174 [1 citation]; Exh. 217, p. 5846 [1 citation]; Exh. 219, p. 5970 [6 citations]; Exh. 220, p. 9807 [1 citation]; Exh. 221, p. 0284 [1 citation]; Exh. 223, p. 9967 [1 citation]; Exh. 224, pp. 2380-2381 [2 citations].)

437. Of those 239 untimely processed claims, there were 63 that fell outside of the MCE period, and therefore were not included in 34,934 figure. (Exh. 22, p. 9512 [2 citations]; Exh. 29, p. 1031 [7 citations]; Exh. 46, p. 0979 [1 citations]; Exh. 53, p. 2883 [6 citations]; Exh. 57, pp. 8684-8685 [8 citations]; Exh. 70 [1 citation]; Exh. 71, p. 8795 [1 citation]; Exh. 72, p. 8878 [1 citation]; Exh. 75, p. 9374 [1 citation]; Exh. 76, p. 8928 [1 citation]; Exh. 78, p. 6139 [2 citations]; Exh. 79, p. 6317 [1 citation]; Exh. 81, p. 5975 [1 citation]; Exh. 87, p. 7477 [11 citations]; Exh. 91, p. 2318 [1 citation]; Exh. 92, p. 2610 [1 citation]; Exh. 93, p. 2752 [1 citation]; Exh. 94, p. 9810 [3 citations]; Exh. 95, p. 0056 [8 citations]; Exh. 96, [1 citation]; Exh. 99 [1 citation]; Exh. 101[1 citation]; Exh. 102, p. 4588 [2 citations].)

438. PacifiCare's failures to fully and correctly pay the thousands of UCSF claims described above are not being charged as acts in violation. They do, however, represent an aggravating factor for purposes of determining the penalty for this violation category.

439. PacifiCare's failures to fully and correctly pay the thousands of UCLA claims and failures to respond to other UCLA claims described above are not being charged as acts in violation. They do, however, represent an aggravating factor for purposes of determining the penalty for this violation category.

3. Determination of Penalty

440. The untimely claims payment of claims is a violation of "average seriousness." (Exh. 1184, p. 101:6-12.)

441. Based on the severity of the violation, and before considering the specific evidence of PacifiCare's violations, Mr. Cignarale recommended placing this violation at 50% of the section 790.035 range, or at $5,000 per willful act, for the calculation of the unit-penalty. (Exh. 1184, p. 101:15-17.)

442. Evidence was presented of aggravation and mitigation pertinent to the factors enumerated in Regulation 2695.12, subdivision (a) with respect to the timely-pay violations.

a. There was slight mitigation based on "relative number of claims" factor (Reg. 2695.12, subd. (a)(7)); slight mitigation for the remedial actions PacifiCare took, albeit belatedly (Reg. 2695.12, subd. (a)(8); and slight mitigation based on the frequency and detriment to public (Reg. 2695.12, subd. (a)(12)). (Exh. 1184, pp. 111:15-112:15.)

b. Under the totality of the circumstances, PacifiCare did not exhibit a good faith attempt to comply (Reg. 2695.12, subd. (a)(12)). (Exh. 1184, p. 112:5-12.) Particularly concerning is PacifiCare's apparently belief that "a certain number of violations were acceptable as long as [its internal claims timeliness] metrics were met." (Exh. 1184, p. 112:8-10.) Also concerning are PacifiCare's refusal to invest in appropriate testing and quality control measures, and its "alarming lack of urgency in addressing issues that the company knew to be causing late-paid claims. . . ." (Exh. 1184, p. 112:7-12.)

c. The harm caused by these violations (Reg. 2695.12, subd. (a)(10)) 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 claims were extremely late. (Exh. 1184, p. 112, p. 1-4.)

d. The delay in taking remedial measures for these violations was also an aggravating circumstance (Reg. 2695.12, subd. (a)(13)). (Exh. 1184, p. 112:16-25.)

e. The remaining penalty factors presented neither aggravating nor mitigating circumstances. (Reg. 2695.12, subds. (a)(1), (a)(3), and (a)(9).)

443. In light of these aggravating and mitigating factors, it is reasonable to increase the unit-penalty by 10%, to $5,500 per willful act in violation. (Exh. 1184, p. 112:26-113:1.)

444. This results in an aggregate penalty of $192,483,500 for these 34,997 acts. (Exh. 1184, p. 113:1-2.)

F. Failure to Pay Interest on Late-Paid Claims

1. PacifiCare's Violations of Law

445. During the 2007 MCE, CDI performed an electronic analysis of PacifiCare's claim population paid during the MCE review period to determine the number of claims that PacifiCare paid more than 30 working days after receipt but contained no payment of interest. (RT 617:22-618:15 (Vandepas).)

446. On December 7, 2007, in response to CDI's verified written examination reports, PacifiCare admitted that it had failed to pay statutorily required interest on late-paid claims in 5,432 instances (5,420 group claims that were paid late but without interest and 12 individual claims that were paid late but without interest). (Exh. 118, pp. 3426-3427.)

447. During the MCE, PacifiCare represented to CDI that the company had reprocessed and paid all interest due on each of these 5,432 claims.

a. In its December 7, 2007, response, PacifiCare represented to CDI that it had completed a project on November 2, 2007, to reprocess and pay the required interest on the 5,420 group claims. (Exh. 118, p. 3426.)

b. PacifiCare also represented to CDI that it had completed a project on October 22, 2007, to reprocess and pay the required interest on the 12 individual claims. (Exh. 118, p. 3427.)

c. PacifiCare further represented that it had paid a total of $138,792.65 in interest for those 5,432 claims — $138,759.00 in interest for the 5,420 group claims and $33.65 in interest for the 12 individual claims. (Exh. 1, p. 3525.)

d. During the MCE, PacifiCare produced to CDI purported evidence of the company's additional interest payments on those 5,432 claims. (Exh. 1, p. 3525.)

448. PacifiCare's representations to CDI that it had reprocessed and paid the statutory interest owed on those 5,432 claims were false.

449. On June 10, 2010, Ms. Berkel testified that the company's prior representations to CDI that it had completed projects to pay statutory interest on all 5,432 claims were incorrect. (Exh. 5252, p. 6937; RT 7646:13-7647:17.)

a. As of June 10, 2010, PacifiCare had failed to reprocess and pay statutory interest on 813 of those claims. (Exh. 5252, p. 6937; RT 7646:13-7647:17 (Berkel).) Those 813 claims were claims that were originally processed in 2006 and 2007. (RT 11271:8-11 (Berkel).)

b. On August 31, 2010, Ms. Berkel testified that the company had completed the reprocessing of those 813 claims, and had determined that 561 of those claims required additional payments of interest totaling $4,049.34.

c. The company claimed that it paid the statutory interest owed on those claims between June and July 2010. (RT 11183:13-11184:20 (Berkel); Exh. 5369, p. 7873.)

450. PacifiCare's reprocessing of those 813 claims was not "self-initiated," as the company contended (RT 11272:21-23 (Berkel).

a. PacifiCare was required by law to reprocess those claims and to pay statutory interest owed on them. This is not an instance in which an insurer itself

discovered claims payment errors, and on its own initiative, reprocessed the claims to pay the correct amounts.

b. CDI discovered these failures in 2007 during the MCE, and PacifiCare had represented in 2007 that it had reprocessed and paid interest on these claims.

c. PacifiCare's reprocessing of these claims three years later in 2010 cannot be considered to have been self-initiated.

451. PacifiCare's contention that it was 99.5% compliant with section 10123.13 is rejected. (See CDI OB, part IV.F.2.)

a. Ms. Berkel testified that PacifiCare was 99.5% compliant with section 10123.13; to achieve that compliance percentage, she compared the number of late-paid claims on which PacifiCare failed to pay interest to the total number of claims PacifiCare paid during the MCE period. (Exh. 5252, pp. 6937-6938; RT 7647:18-7648:22 (Berkel).)

b. That does not accurately reflect PacifiCare's compliance with the interest requirement. To measure compliance with the interest requirement, the appropriate comparison would be the number of claims on which PacifiCare failed to pay interest and the number of claims that actually required PacifiCare to pay interest. (RT 10076:7-10 (Berkel).)

c. Using that formula, PacifiCare complied with the interest requirement 82% of the time. (See Exh. 724.)

452. As Ms. Berkel testified, PacifiCare's 82% compliance rate with the interest requirement is not satisfactory. (RT 10076:7-14.)

453. The corrective actions that PacifiCare claims to have implemented to address its failures to pay interest were ineffective. (See CDI OB, part IV.F.2.)

a. PacifiCare's corrective actions only addressed its failure to pay interest on rework claims, and did not address its failures to pay interest on "new day" claims. (Exh. 5252, pp. 6939-6940; RT 10066:10-16 (Berkel).)

b. These corrective actions were implemented in October 2007, November 2007, and January 2008. (RT 7649:9-17; 7650:5-19 (Berkel); Exh. 5252, p. 6940.)

c. Ms. Berkel admitted at the hearing that the company continued to struggle with performing interest calculations even after these corrective actions were implemented. (RT 10067:24-10068:3; see also RT 10068:4-9 (Berkel) ["Q. [By Strumwasser] So even after you had the [interest calculator] template, you were having problems? A. Yes, we were."].)

d. In an October 2008 e-mail, Ms. Berkel reported that the company was "[s]till struggling with RIMS PPO interest accuracy." (RT 10072:9-13 (Berkel); Exh. 712, p. 9316.)

454. The company failed to identify and remediate other root causes of its failures to pay interest on late claims.

a. Ms. Berkel testified that RIMS did not automatically calculate interest on readjudicated claims, so an examiner must manually calculate interest. (Exh. 5252, p. 6939; RT 7648:23-7649:8.) Ms. Berkel therefore concluded that the root cause of these failures to pay interest was human error. (RT 7648:23-7649:8.)

b. Ms. Berkel's explanation does not account for PacifiCare's failure to pay interest on "new day" claims. (RT 10065:5-13 (Berkel).)

c. PacifiCare presented no evidence of the root cause of its failures to pay interest on "new day" claims, and presented no evidence of any corrective actions for those failures. (RT 10066:10-16 (Berkel); Exh. 5252, pp. 6939-6940.)

455. One significant root cause of the company's failures to pay required interest was its flawed policies and procedures for recording claim received dates in RIMS. (See CDI OB, part IV.F.2.)

a. For rework claims, PacifiCare's standard practice was to record as the "received date" in RIMS the date that the request for rework was received, not

the original date that the claim was received. (RT 2368:15-18; 2369:9-12 (Norket).)

b. It was then left to the claims examiner to find the original received date of the claim and to manually change it so that interest would be calculated correctly. (RT 2368:18-25; 2363:9-24; 2369:9-16 (Norket).)

c. If the claims examiner didn't manually change the received date on the rework claim, the claim would be processed as though it was received by the company on the date that the rework request was received, not on the date that the claim was actually received. This would cause interest to be incorrectly calculated, and would lead to late-paid claims not being paid any interest or not being paid the correct amount of interest.

d. The company took no corrective actions to address this issue.

456. The loss of PacifiCare's institutional knowledge during the integration also contributed to the company's failures to pay required interest. (See CDI OB, part IV.F.2.)

a. In 2006, shortly after the acquisition of PacifiCare by United, the company closed PacifiCare's operations in the Cypress headquarters office and laid off the experienced PPO claims examiners there. (Exh. 283; RT 2293:16-25 (Norket); RT 9016:12-24 (Monk).)

b. Those layoffs resulted in the loss of historical knowledge in PacifiCare's claims operation (Exh. 5265, p. 1945 ["Historical knowledge is intentionally severed"]), which before the acquisition was functioning well (RT 2318:3-7 (Norket)).

c. PacifiCare then transferred nearly all PPO claims processing to the vendor MedPlans, and by late 2007, PacifiCare was "absolutely dependent" on MedPlans for PPO claims processing. (Exh. 528, p. 2687 ["Now that we have transitioned most of our PPO claims processing to them"]; RT 6194:11-23 (Vonderhaar) ["They [MedPlans] were doing pretty much everything else already."]; see also RT 6188:16-24 (Vonderhaar); Exh. 560, pp. 4878-4879.)

d. Even though PacifiCare was continually dissatisfied with MedPlans's performance, it continued to transfer more PPO work to that vendor. (Exh. 1032 ["the quality levels we are seeing [at MedPlans] are really a cause for termination"]; Exh. 560, pp. 4878-4879 [describing performance as "unacceptable"].)

e. The laying off of experienced PPO claims examiners in 2006, and the transferring of PPO claims processing to MedPlans — a vendor with known performance issues — contributed to PacifiCare's failures to appropriately pay interest on claims.

457. Claimants are harmed when they are not paid interest on late-paid claims because they are not being fully and accurately paid what they are owed. (Exh. 1184, p. 113:21-23.)

458. The failure to pay statutory interest on a claim causes the same type of harm as does an underpayment of a claim. (Exh. 1184, p. 113:23-24.)

459. In some instances interest owed on a claim may be small, but in others it is significant, and will have substantial adverse effects on claimants.

a. Ms. Berkel testified that of the claims that the company failed to pay any interest on, the average amount of interest owed after these claims were reprocessed was around $30 per claim. (RT 10061:13-10062:2; Exh. 5252, p. 6938.)

b. Twenty-five of these additional interest payments exceeded $1,000, and one claim, which was originally submitted in 2004, was reprocessed 3 years later with an additional interest payment of approximately $21,000. (RT 10062:10-17; 11185:14-25 (Berkel).)

460. An insurer's failure to pay statutorily required interest also creates unnecessary administrative burdens on claimants who are forced to track down information about particular claims they had submitted and to follow up with insurers to ensure that appropriate interest is paid. (Exh. 1184, p. 113:20-27.)

461. Given PacifiCare's poor and ineffective customer service, the administrative burdens of having to deal with PacifiCare to get claims fully and correctly paid were likely significant.

462. In those instances in which the interest payment was small (see Exh. 5639, p. 7874), the administrative burdens imposed on claimants far exceeded the amount that the interest payment compensated them for. (See Exh. 1184, p. 118:14-16; RT 10039:11-10040:5 (Berkel).)

2. Number of Acts in Violation

463. PacifiCare admitted at the hearing that there were a total of 5,195 claims on which it failed to pay statutory interest in violation of the law. (Exh. 5369, p. 7874.)

464. That figure represents the number of claims that were paid late (more than 30 working days after receipt) with $0 in interest.

465. CDI did not attempt to determine, and PacifiCare did not disclose, the number of late-paid claims that were paid an incorrect amount of interest.

466. Given the serious problems PacifiCare was having paying interest, it is likely that the number of acts in violation is significantly higher than 5,195.

3. Determination of Penalty

467. The failure to pay interest on late-paid claims is generally a "less serious than the average" violation. (Exh. 1184, p. 114:20-27.)

468. Consistent with its level of severity, such violations justify a unit-penalty at 20% of the maximum of the section 790.035 range, or at $2,000 per willful act, for the calculation of the unit-penalty. (Exh. 1184, p. 114:3-5.)

469. Evidence was presented of mitigation or aggravation pertinent to five of the factors enumerated in Regulation 2695.12, subdivision (a) with respect to these failure to pay interest violations.

a. Even though PacifiCare's 82% compliance rate for paying required statutory interest on late-paid claims was "unsatisfactory," the "relative number of

claims" factor (Reg. 2695.12, subd. (a)(7)) was slightly mitigating. (Exh. 1184, p. 117:16-24.)

b. The remedial actions taken (Reg. 2695.12, subd. (a)(8)) was a mitigating factor. (Exh. 1184, pp. 117:25-118:3.)

c. The harm caused by these violations (Reg. 2695.12, subd. (a)(10)) was a mitigating factor. (Exh. 1184, p. 118:6-17.)

d. Under the totality of the circumstances, PacifiCare did not exhibit a good faith attempt to comply (Reg. 2695.12, subd. (a)(11)), which was slightly aggravating. (Exh. 1184, p. 118:18-25.)

e. PacifiCare's delay in remediating all the claims (Reg. 2695.12, subd. (a)(13)) was an aggravating factor. (Exh. 1184, p. 119:3-9.)

f. There was no evidence of mitigating or aggravating circumstances from extraordinary circumstances surrounding these violations (Reg. 2695.12, subd. (a)(1); see Reg. 2695.2, subd. (e)), in the complexity of the claims (Reg. 2695.12, subd. (a)(3)), or from PacifiCare's prior compliance record (Reg. 2695.12, subd. (a)(9)).

g. The factors enumerated in subdivisions (a)(2), (a)(4), (a)(5), (a)(6), and (a)(14) do not apply to the claims at issue here.

470. Taken together, the evidence of PacifiCare's violations of the interest statute are slightly mitigating and justify a 15% downward adjustment to the unit-penalty for this category, resulting in $1,700 per act in violation. (Exh. 1184, p. 119:10-13.)

471. This results in an aggregate penalty of $8,831,500 for these 5,195 violations. (Exh. 1184, p. 119:13-14.)

G. Failure to Correctly Pay Claims

1. PacifiCare's Violations of Law

a. Complaints, Investigation, Market Conduct Exam

472. In late 2006, CDI began receiving an influx of provider complaints about a number of issues with PacifiCare's claims handing, including the incorrect payment of claims. (RT 351:19-25 (Masters); Exh. 5, p. 0705; Exh. 7.)

a. Around the same time, CMA providers were complaining about PacifiCare's failure to timely load contracts, to accurately load agreed-upon rates, and to properly reflect providers' contracted or non-contracted status. (Exh. 1019, p. 7974; Exh. 165, pp. 8506-8507.)

473. When CDI questioned PacifiCare about these issues in early 2007, PacifiCare was not forthcoming about the problems it was facing; instead, it attempted provided vague responses to CDI and withheld relevant information. (See CDI OB, part IV.G.2.a.)

a. For example, PacifiCare indicated that it had changed its method of maintaining provider data, but portrayed the changes as "not significant." (Exh. 7 [see number 8].)

b. The change to maintaining provider data was the implementation of the EPDE feed, which resulted in significant problems including massive corruption of provider demographic data and fee schedules. (See CDI OB, part IV.G.2.a; see also CDI OB, part II.F.2.b.)

c. CDI asked PacifiCare to explain what quality control measures it had in place to verify the accuracy of claims processed after the use of EPDE began. PacifiCare told Ms. Smith that "they had something but they would explain to me fully at . . . a different date." (RT 111:21-112:7 (Smith); Exh. 7 [number 8].)

d. Ms. Smith wrote to Ms. Henggeler in a March 20, 2007, e-mail:

> "Company statements to date have been rather vague about exactly what system fixes and verifications it has done, and when, regarding the various programming and other system glitches that have led to the claims processing problems post 6/23/06. The company personnel reporting info to us do not

seem to interact with their system department nor do they seem familiar with systems procedures." (Exh. 10, p. 7785; Exh. 7 [see number 8]; RT 111:21-112:7 (Smith).)

e. In March 2007, PacifiCare told CDI that "the net financial impact of these three challenges (retro-effective contract loads, fee schedule corrections and demographic errors) is estimated to be approximately $250K in provider underpayments requiring adjustments." (Exh. 8, p. 1870.)

f. After CDI staff challenged this figure as unrealistic, the company admitted that the figure did not, in fact, represent the "net financial impact" of those three operational errors. (Exh. 9, p. 0620; Exh. 5348, p. 8450 [see number 4].)

474. When CDI examined PacifiCare's contract loading processes during the MCE, it found serious deficiencies, contrary to PacifiCare's previous representations to CDI.

a. For instance, CDI found that the company "failed to institute provider contract upload mechanisms, required as the result of provider contracting efforts, to ensure timely initiation of contract terms. Consequently, provider claims were not processed correctly as the result of delayed uploading." (Exh. 118, p. 3422 [see number 10].) PacifiCare did not dispute these findings. (Exh. 118, p. 3422 [see number 10].)

b. 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].) PacifiCare similarly "acknowledge[d] that many provider contracts were loaded after the effective date." (Exh. 118, p. 3423 [see number 11].)

c. PacifiCare further admitted that it had not reprocessed all the claims mispaid as a result of contract loading delays:

"PacifiCare has admitted it did not consistently address problems in claims adjudication when provider contract uploading was delayed or contracts were back dated. Additionally, PacifiCare cannot verify that all claims submitted prior to contract uploading or contract back date were reviewed for correct payment and interest where applicable." (Exh. 118, p. 3423.)

475. During the MCE, CDI identified at least 14 providers with approximately 500 claims representing billed charges of $96,000 that PacifiCare had not yet reworked. (Exh. 1, p. 3522.)

476. As discussed below, the evidence in the record reflects that PacifiCare mispaid at least tens of thousands of claims throughout 2006 to 2008.

b. **Root Causes of the Violations**

477. One of the root causes of these mispaid claims was that PacifiCare failed to timely load provider contracts. (Exh. 1, p. 3522; RT 10674:13-10675:5 (McFann).)

478. As a result, claims would be incorrectly processed according to an outdated contract or, if the provider had no previous contract with PacifiCare, would be incorrectly paid at non-contracted rates. (RT 2209:22-2210:9 (McFann).)

479. PacifiCare's implementation of the EPDE feed to transfer provider demographic data and fee schedule data also contributed to the mispaid claims.

480. PacifiCare implemented EPDE in a rushed and poorly planned manner. (See CDI OB, part IV.G.2.a; see also CDI OB, part II.F.2.b.)

a. PacifiCare decided to implement EPDE in California in June 2006 to begin realizing synergies as soon as possible. (Exh. 395, p. 1146; RT 15223:21-25; 17309:12-13 (Lippincott).)

b. PacifiCare did not sufficiently test EPDE before launching it. (Exh. 921, p. 5189; Exh. 759, p. 6084; RT 8231:3-9 (Berkel).)

c. The company failed to resolve data discrepancies between NDB and RIMS before launching EPDE. (Exh. 759, p. 6084; Exh. 713, p. 9518 ["lack of reconciliation of Provider data amongst various systems."]; RT 12766:8-12767:14 (McFann).)

d. The company failed to analyze and resolve structural incompatibilities between NDB and RIMS before launching EPDE. (Exh. 759, p. 6084.)

e. This failure to analyze or test for the implications of differing architecture in NDB and in RIMS led to serious programming errors. (RT 10845:3-12;

12774:5-12 (McFann); Exh. 771, p. 5859; Exh. 917, p. 6488; Exh. 954, p. 2782 [Mimick 11:36 a.m.]; Exh. 955 [Tonto 2:33 p.m.].)

f. PacifiCare did not adequately train staff on the use of EPDE and its implications for their work functions. (Exh. 602, pp. 1240, 1241; Exh. 898, p. 4739; Exh. 980, p. 8865; RT 10993:9-10994:17; 12841:1-19 (McFann); 16481:23-16482:15; 16089:7-20 (Lippincott).)

481. Using a data bridge, such as EPDE, as a long-term solution carried significant risks of corrupting provider data. (Exh. 1093, p. 27:14-28:4.) The company was aware of these risks, but nevertheless went forward with the EPDE feed. (Exh. 395, pp. 1149, 1222; Exh. 947, p. 0396; Exh. 392, p. 2137.)

a. As United's VP of Provider Data Integrity, Matt Guisinger, stated in a September 2007 e-mail: "If it is not a direct connect, it is a band aid. EPDE helps, but would not be an end state goal — just a bridge until we can establish a direct connect if a platform will be with us for a little while." (Exh. 947, p. 0396.)

b. Ronald Boeving similarly testified that "United's decision to use the EPDE feed — which worked as [a] data bridge transferring data from one system to another — as a means to keep RIMS data updated and in sync was itself also unacceptably risky." (Exh. 1093, p. 27:14-16.)

c. "A data bridge is not an appropriate strategy for true integration; it is a temporary solution for when there is no ability to manage the other side of the bridge . . . . the quality of the data bridge is only as good as its last data transfer, and every data transfer presents risks of errors." (Exh. 1093, p. 27:16-21.)

d. Like Mr. Guisinger, Mr. Boeving concluded that "United should have implemented an integrated connection between RIMS and NDB so that RIMS could directly access the data in NDB." (Exh. 1093, p. 27:22-23.)

e. United's failure to build a direct connection between RIMS and NDB "created unnecessary risk in the process and likely caused and exacerbated many of the data errors in RIMS." (Exh. 1093, pp. 27:28-28:4.)

482. The record contains significant evidence establishing that the nightly EPDE data transfer between NDB and RIMS caused corruption of provider data, which resulted in, among other problems, incorrect claim payments. (Exh. 917, p. 6488 ["Whenever there is any change to a provider record in NDB, an entire new record is sent from NDB to RIMS in the nightly update process via the Autoload program. When there are multiple billing address records within RIMS, the EPDE/PHS Autoload program becomes confused and remits the record to the default suffix. Often the default suffix contains a cancelled or termed address."].)

483. The quality of the provider data that was being transferred into RIMS was of questionable reliability and accuracy.

a. PacifiCare manager Christina Sheppard raised concerns about "questionable data" imported from CTN and "the potential to overwrite clean records in RIMS with bad NDB data." She brought these concerns to the executives in charge of the decision to use CTN data to maintain RIMS, but was not heeded. (Exh. 773, p. 2319; RT 10998:23-11000:14; 11002:3-11003:18 (McFann).)

484. The company was slow to react to problems with the EPDE feed. Instead of responding to remediate issues with EPDE, management ignored the problems and even denied that they existed.

a. PacifiCare was aware soon after its implementation that EPDE was causing significant claims payment errors. (Exh. 435, p. 3699 [date of 8-8-06, "changes to EPDE required"]; Exh. 767, p. 3317; Exh. 544, p. 6721; Exh. 354, p. 7181 [number 11].)

b. As Mr. Chan complained in a September 2007 e-mail, "I've been battling with this EPDE issue for quite some time now. I have been attacked, brutalized and brought to my knees. This process has corrupted all my Ancillary and

Hospital records, caused a lot of additional work (aside from fixing the corrupted records) and yet they put the accountability on me to figure out what the root cause is when the folks who created/implemented this process should [be] explaining to me what they are doing to corrupt my records in RIMS." (Exh. 501, p. 5933 [Chan 9:40 a.m.].)

c. Mr. Chan continued: "Reality is, there is indeed something wrong with this EPDE process but they are refusing to admit that there is an issue (getting too political for me)." (Exh. 501, p. 5933 [Chan 9:40 a.m.].)

d. Ms. McFann responded to Mr. Chan: "you are not a lone voice in the darkness on this, i promise," indicating her apparent agreement with his comments about the problems with the EPDE feed. (Exh. 501, p. 5933 [McFann 4:04 p.m.].)

e. PacifiCare failed to bring together staff from different departments to collaboratively manage EPDE issues until a year after implementation. (Exh. 602, p. 1241 [June 2007 War Room].)

f. The evidence reflects that PacifiCare failed to address a known flaw in the EPDE logic that was corrupting provider data until March 2007. (Exh. 921, p. 5189; Exh. 916, p. 9427). And even after then, several further enhancements were subsequently required throughout 2008 and in early 2009. (Exh. 950; Exh. 505, p. 1589; Exh. 506, p. 3785; Exh. 677, p. 4417; RT 16226:4-7 (Lippincott).)

g. The evidence also reflects that in some instances, the company deliberately decided not to address known data corruption in RIMS. (Exh. 956, p. 5196; Exh. 957, p. 8303; RT 16189:21-16190:10 (Lippincott).)

h. PacifiCare did not take meaningful steps to assess and improve the accuracy of RIMS data until August 2007. (Exh. 602, pp. 1238, 1239, 1245; RT 8247:8-13; 8252:25-8253:25 (Berkel).)

i. As Mr. Boeving observed, efforts to "get issues with the end-to-end process addressed and resolved" were "largely unsuccessful because of the focus on protecting the reputation of the EPDE feed and an apparent reluctance to allocate resources to these quality measures." (Exh. 1093, p. 10:9-14.)

j. Mr. Lippincott, in particular, appeared more interested in "trying to clear EPDE's name" (Exh. 919, p. 5200 [Lippincott 12:42 a.m.]) than in correcting the actual problems (Exh. 1093, p. 9:20-10:7.)

485. As a result of the slow response — or in some instances lack of response — by management, many provider data errors unnecessarily persisted for months, during which time claims continued to be paid improperly; as Ms. McFann noted, this was "totally unacceptable." (Exh. 5354, pp. 8205 [Dr. Sun], 8206 [Dr. Castellanos], 8207 [Women's Healthcare, Dr. Borok]; Exh. 477, p. 0274 [McFann 7:45 a.m. (number 3)]; Exh. 481; RT 4940:2-8 (McFann).)

486. Exacerbating the problems with EPDE was that the reconciliation reports implemented by PacifiCare, which were supposed to detect issues, were inadequate (Exh. 977; Exh. 978; Exh. 699, p. 4152; RT 16432:6-21 (Lippincott)) or were not consistently monitored (Exh. 968, p. 8487; Exh. 970, p. 9675 [Mimick 7:18 a.m.]; RT 16376:12-23; 16381:14-15 (Lippincott).)

a. For instance, Ms. Mimick reported in an August 2007 e-mail: "Frankly, there is not [a] solid process on how error reports are worked — there are surprises there as well. We have the one report that Bo was not working back under control, but myth and legend prevail on what constitutes working the reports at this point." (Exh. 970, p. 9675 [Mimick 7:18 a.m.].)

b. Ms. Mimick also reported in a September 2007, e-mail: "at yesterdays [sic] PHS meeting, the Network folks stated they have determined that the RIMS data reconciliation reports are not working — they are not pulling through enough mis-matches." (Exh. 977 [Mimick 7:40 a.m.].)

487. As a result, many problems with the EPDE process were discovered only after external customers complained to the company. (Exh. 1093, p. 11:20-23.)

a. Ms. Mimick expressed her frustration about the company's inability to detect problems: "We cannot continue to rely on the provider community to discover issues for us." (Exh. 956, p. 5196 [Mimick 10:02 a.m.].)

488. PacifiCare has pointed to United's loss of the CTN network as a root cause for PacifiCare's contract loading issues. That is not an excuse for PacifiCare's failure to pay claims correctly.

a. In a March 2007 presentation to CDI, PacifiCare contended that the termination of the CTN agreement for United was the cause of many of the contract loading issues and attendant claim-payment problems the company has having. (Exh. 8, pp. 1865, 1867-1870; RT 9166:6-11 (Monk).)

b. In the company's responses to the MCE reports, it claimed that the loss of the CTN network was the cause of provider contracts being loaded after their effective dates. (Exh. 118, p. 3422.)

c. At the hearing, PacifiCare's expert contended that the CTN transition constituted an "extraordinary circumstance," as that term is defined in the Regulations. (Exh. 5707, p. 9.)

489. First, the loss of the CTN network affected only United members, not PacifiCare members.

a. As Ms. Monk admitted on cross: "PLHIC membership did not lose access to CTN providers at the time [of the CTN transition]." (RT 9155:16-18.)

b. As PacifiCare has admitted, the CTN transition had "by definition, nominal impact on PLHIC." (Exh. 5252, p. 6928.)

490. The testimony from PacifiCare witnesses that the loss of the CTN network was "unexpected" and a "surprise" is not credible. (RT 10794:3-9 (McFann); Exh. 5341, p. 7857.)

a. PacifiCare/United fully expected and anticipated needing to transition off the CTN network within six months.

b. PacifiCare/United knew that Blue Cross could, at any time on six months' notice, terminate the CTN network. (Exh. 758, p. 9291; RT 10791:19-10792:1 (McFann).)

c. Even before receiving the termination notice from Blue Shield, United had plans to transition off the CTN network by June 2006. (Exh. 5343, p. 7737 [see bullet 2 under "Network"].)

d. United acquired PacifiCare so that it could transition off the CTN network. (Exh. 426, p. 9021; RT 4872:15-4873:7 (McFann).)

e. According to a legal analysis performed by United's lawyers and submitted to the Department of Justice in connection with the acquisition, under the terms of the CTN agreement at the time of the acquisition, United would have had to stop using the CTN contract within six months even if Blue Shield had not exercise its termination rights:

> "If the [CTN] agreement is not terminated (an "Option Event"), subject to BSC's right of first offer and first refusal, within six months from the acquisition UHG must enter into an agreement to sell the PHS assets that 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 the PHS acquisition unless the NAA is renegotiated." (Exh. 758, p. 9291, fn. 7.)

491. The testimony from PacifiCare's witnesses that the CTN transition was a "tremendous undertaking," requiring the recontracting of 9,000 physicians (RT 7372:25-7373:2 (Berkel); Exh. 5252, p. 6928; see also Exh. 5259, p. 9897) is not credible.

a. Contemporaneous documents reflected the company portraying the loss of the CTN network as "not a burning issue for us" and something "we do not want to over emphasize" (Exh. 673, p. 9889), and reporting that "[t]he story [for the

CTN transition] is a good one and will only get better for our clients" (Exh. 674, p. 8610 [Kueter 5:30 a.m.]).

b. In June 2006, United further represented that its network "has very little disruption from the CTN network" and that "[o]n the actual date of network transition, we anticipate that our customers will have access to substantially identical or even greater numbers of hospitals, specialists and primary care physicians in California." (Exh. 675, p. 3769.)

c. United had previously determined that it needed to contract with only about 4,000 of those doctors who had actually seen a United member in the past year; United acknowledged that these were the "doctors that truly matter." (Exh. 676, p. 5921; see also Exh. 629, p. 1966.)

d. In January 2006, United considered "cutting over to just a PacifiCare network solution" (meaning relying on the PacifiCare network and newly contracted gap providers) on April 1, ahead of the June 23 date permitted by the CTN lease agreement. (Exh. 861, p. 8936 [Brockman 6:39 p.m.]; RT 12877:18-12878:6 (McFann).)

e. In total, PacifiCare executed fewer than 3,000 contracts by January 2007 to close the CTN "gap." (Exh. 756, p. 8173; RT 10779:13-10780:2 (McFann).)

c. **Harm Caused by the Violations**

492. Mispaid claims harm both members and providers by not paying them what they are entitled to. This may result in adverse financial consequences, cause emotional distress and mental anguish for patients and doctors worried about medical bills and expenses, create undue administrative burdens on claimants who must appeal or seek the assistance of CDI to get claims resolved, and lead to patients being denied treatment or delaying or forgoing needed treatment. (Exh. 1184, pp. 63:20-64:4; RT 2685:8-13 (K. Griffin).) [administrative burdens on providers].) These represent serious harms.

493. Incorrect payments cause friction between providers and patients, harming the doctor-patient relationship. (RT 2698:4-13 (K. Griffin).); RT 3052:2-8 (Mazer).)

494. The harm in this case was greater than the ordinary case. (See CDI OB, part IV.G.2.c.)

495. Many of the mispaid claims resulting from late loading of contracts, fee schedule errors, and EPDE errors were not remedied for six months or more. (E.g., Exh. 262, pp. 6, 11, 13-16, 20; Exh. 1019, p. 7977 [Watson].)

496. Providers were forced to expend significant energy seeking restoration of their contracted reimbursement rates, during which they continued to have their claims mispaid.

a. One doctor, for instance, had to make approximately 35 calls to the company over the course of around nine months, and had to have the CMA intervene before PacifiCare finally uploaded his contract. (Exh. 1019, p. 7977 [Watson].)

b. Statutory interest due on late-paid claims did not adequately compensate providers for "all the time and grief" that PacifiCare's underpayments caused. (RT 2685:8-13; 2689:4-12 (K. Griffin).)

497. The evidence demonstrates that patients were harmed, as well. (See CDI OB, part IV.G.2.c.)

a. When providers are paid an incorrect amount, the member's copay and deductible are incorrectly calculated. (RT 2232:22-2234:1 (McFann).)

b. When PacifiCare resolved its mispayments to providers by lump sum settlement — for example, as the company did with UCSF and UCLA — rather than readjudicating the incorrectly processed claims, the members did not receive EOBs and were unaware that their copay or deductible were incorrect. (RT 2234:16-2236:9 (McFann).)

c. There was no evidence that PacifiCare remediated its incorrect claim payments as those mispayments affected members.

d. When patients are told their provider is out-of-network, as PacifiCare did here, they feel anxious that they will end up owing more money than anticipated. (RT 2699:1-8 (K. Griffin).)

498. The harm here was further exacerbated by PacifiCare's poor customer service. (See CDI OB, part IV.G.2.c.)

a. Members and providers who attempted to contact PacifiCare regarding incorrect payments often found they "couldn't get anybody to answer the phone" or left repeated messages without return calls. (Exh. 5354, p. 8206; RT 2668:22-2269:12 (K. Griffin); Exh. 286.)

b. Customer service staff provided inaccurate information, instructed callers to resubmit already-submitted disputes, and failed to return phone calls. (Exh. 287, p. 6168 [Mimick 5:05 p.m.]; Exh. 349, p. 6624; Exh. 289, p. 6599; Exh. 627, p. 0408; Exh. 5320, p. 8939; Exh. 1033, pp. 5468-5469 [Berkel 12:59 a.m.]; RT 1727:21-1728:7 (Mr. R.).)

c. Providers spent an inordinate amount of time pursuing appeals of wrongly denied or improperly adjudicated PLHIC claims, and the lack of timely responses created significant frustration. (Exh. 1019; RT 2674:15-21 (K. Griffin); RT 2668:14-2669:12 (M. Griffin).)

d. As United's senior officer, David Wichmann, described PacifiCare's service in 2007: "In two words: We stink." (Exh. 945, p. 1059 [Wichmann 12:31 p.m.].) He further complained that the company needed to "remediate PHS service which is a complete mess due to poor operational integration." (Exh. 945, p. 1059 [Wichmann 12:31 p.m.].)

499. The harm to providers from mispaid claims was further aggravated by PacifiCare's failure to timely respond to provider disputes, as discussed below. (See pp. 152-157, *infra*.)

500. The data corruption caused by EPDE also caused providers to be dropped from PacifiCare's online directories. (Exh. 951, p. 5463.) This causes "loss of significant business" for the provider as PacifiCare members chose to take their business elsewhere (Exh. 5625, p. 4868) and confusion for members who sought in-network providers. (Exh. 702, p. 5475.)

2. Number of Acts in Violation

501. PacifiCare admitted that it had incorrectly processed at least 3,700 claims due to "retro loaded contracts or associated with the CTN transition." (RT 2212:12-15 (McFann).)

502. This number likely represents a small fraction of the mispaid claims that resulted from the problems that PacifiCare has characterized as "associated with the CTN transition," including delays in contract loading, failures to maintain fee schedules, and EPDE's corruption of provider demographic and contract data.

a. A significant proportion of California provider data was inaccurate. (Exh. 767, p. 3316; Exh. 965, p. 5838.)

b. The nonstandard fee schedules, which represent the vast majority of PLHIC fee schedules, were not maintained between June 2006 and March 2007.

c. RIMS rework was at "unacceptable levels" during the market conduct exam period. (Exh. 408, p. 7619.)

d. By January 2007, PacifiCare had already identified 38,000 claims that had to be reworked due to late contract submissions, the "PTI" issue, and a RIMS-NDB mismatch, and another 23,000 claims that were underpaid 5% on average due to a fee schedule that was not maintained. (Exh. 850, p. 8068.)

e. It is reasonable to infer that these problems resulted in large scale claims payment errors.

503. PacifiCare's claims data reflects 78,320 PacifiCare claims that were initially incorrectly paid and had to be reprocessed during the MCE review period. (Exh. 1156; Exh. 1165; Exh. 1166 [number of rework claims less claims representing overpayment reimbursements equals 78,320]; Exh. 1167 [same].)

504. PacifiCare incorrectly paid thousands of PPO claims to the UCSF medical group from January 1, 2006, through March 14, 2008. (RT 4153:13-4154:1 (Martin).)

a. PacifiCare admitted that it had mispaid these claims, acknowledging that the company had failed to load the correct fee schedule for that provider group. (RT 4150:11-20, 4152:15-22 (Martin).)

b. The number of claims with dates of service from 2006 through March 14, 2008, is in evidence and is undisputed by PacifiCare.

c. 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.)

505. PacifiCare acted in bad faith with respect to purporting to resolve these claim underpayments to UCSF. (See CDI OB, part IV.G.2.a.)

a. The company knew, but concealed from UCSF, that it had been paying claims to UCSF incorrectly since 2004. (Exh. 485, p. 4073; RT 11863:23-11864:5 (Harvey).)

b. It then negotiated with UCSF to determine that the claims that needed to be part of a lump-sum settlement were claims with dates of service from January 1, 2006, to March 14, 2008. (RT 4153:8-4154:1 (Martin).)

c. It then proposed to obtain, as part of the settlement, UCSF's agreement that the company had paid all claims with dates of service on or before March 14, 2008, "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).)

506. PacifiCare also systematically underpaid thousands of claims to UCLA around the same time, from the beginning of 2007 through March 14, 2008. (RT 3791:7-17 (Rossie).) In response to a request from PacifiCare (RT 3859:9-14 (Rossie)), UCLA produced claim data spreadsheets reflecting that PacifiCare underpaid at least 1,333 claims during that period. (Exh. 613; Exh. 614; Exh. 615; Exh. 616.)

3. Determination of Penalty

507. The incorrect payment of claims is of "average seriousness." (Exh. 1184, p. 63:20-21.) Accurate claims payment is a central obligation of insurers; failure to meet that obligation poses adverse financial and administrative consequences for providers and can lead to friction between providers and patients. (Exh. 1184, p. 63:21-64:4.)

508. Consistent with this level of severity, such violations justify a unit-penalty at 50% of the maximum under section 790.035, or $5,000 for each willful act in violation of section 790.03. (Exh. 1184, p. 85:19-23.)

509. Mr. Cignarale found evidence of mitigation or aggravation pertinent to the factors enumerated in Regulation 2695.12, subdivision (a) with respect to these violations.

a. There was no evidence of extraordinary circumstances (Reg. § 2695.12, subd. (a)(1)), as that term is defined in the Regulations (Reg. § 2695.2, subd. (e)). (Exh. 1184, p. 95:14-27.)

b. The complexity (Reg. 2695.12, subd. (a)(3)) associated with claims adjudicated pursuant to a non-standard fee schedule is a slightly mitigating factor. (Exh. 1184, p. 96:1-6.)

c. The remedial measures (Reg. 2695.12, subd. (a)(8)) undertaken by PacifiCare warrant slight mitigation. (Exh. 1184, p. 96:10-21.)

d. The harm occasioned by PacifiCare's mispaid claims (Reg. 2695.12, subd. (a)(10)), is a factor in aggravation based on PacifiCare's delay in correcting corrupted provider data and based on the inadequacy of PacifiCare's customer service, which exacerbated provider and consumer frustration. (Exh. 1184, pp. 96:24-97:5.)

e. The absence of a good faith attempt to comply is an aggravating factor. (Reg. 2695.12, subd. (a)(11).) PacifiCare transferred most claims processing to MedPlans despite serious concerns about its past quality performance and continuing suspicions that its payment structure made errors more likely. PacifiCare also deployed a large-scale data transfer project, which it was

aware posed serious risks of data corruption, without adequate analysis, testing, or quality control. PacifiCare's reckless acts invited claims payment errors and demonstrate a lack of good faith. (Exh. 1184, pp. 97:6-98:2.)

f. PacifiCare's management was aware of facts that apprised the company of violations and the need to take remedial measures. (Reg. 2695.12, subd. (a)(12).) The company did not timely fix the EPDE logic errors, failed to identify all corrupted data, did not analyze root causes of the data corruption, and failed to implement quality control audits or reconciliation procedures. (Exh. 1184, p. 98:6-20.)

510. Mr. Cignarale concluded that, taken together, this evidence reflected aggravating circumstances and warranted a 20% upward adjustment of the unit-penalty, to $6,000 per act in violation. (Exh. 1184, p. 98:21-23.)

511. The thousands of additional uncharged violations are further evidence in aggravation that Mr. Cignarale did not consider. (E.g., *Grim*, *supra*, 53 Cal.3d at pp. 33-34; *Ralph Williams Ford*, *supra*, 30 Cal.App.3d at pp. 499-500; see also RT 10450:7-22.)

a. Uncontroverted evidence shows that PacifiCare mispaid thousands of additional claims to UCLA and UCSF, totaling 4,457 additional uncharged acts in violation. (Exh. 613; Exh. 614; Exh. 615; Exh. 616; Exh. 619.)

b. The evidence further reflects that PacifiCare acted in bad faith with respect to the UCSF mispaid claims.

c. PacifiCare's claims data reflects that the company had to reprocess 78,320 previously incorrectly paid claims during the market conduct review period. (Exh. 1156; Exh. 1165; Exh. 1166 [number of rework claims less claims representing overpayment reimbursements equals 78,320]; Exh. 1167 [same].) These incorrect payments are not being charged in this action.

512. The existence of this large number of uncharged violations warrant a 40% increase over Mr. Cignarale's adjusted unit-penalty recommendation. The maximum unit-penalty, $10,000 per act in violation, is appropriate under these circumstances.

The aggregate penalty for this category of violations is $37,000,000.

H. Failure to Acknowledge the Receipt of Claims

1. PacifiCare's Violations of Law

a. PacifiCare's Contemporaneous Interpretation of Acknowledgment Requirement

513. PacifiCare's implementation log for the Regulations reflects the company's understanding that Regulation 2695.5, subdivision (e) requires that insurers send letters acknowledging the receipt of claims to both members and providers.

a. As discussed above, PacifiCare generates implementation logs for the purpose of setting forth the requirements for a law or regulation and the actions that the company believes need to be taken to comply. (RT 8893:18-8894:19; 9051:25-9052:3; 12452:11-20 (Monk).)

b. PacifiCare also uses implementation logs as an activity-tracking document to monitor what actions the company has performed and what actions it still needs to perform in order to comply with the law. (RT 8893:18-8894:19 (Monk).)

c. PacifiCare's implementation log for the Regulations contained: (i) a column titled "Action Item," which reflected the "action items that must be taken by PacifiCare to comply with the regulation or law"; and (ii) an "Action Taken" column, which reflected the "actions that have already been taken to comply with the regulation or law." (Exh. 811; RT 12452:11-20 (Monk).)

d. For Regulation 2695.5, subdivision (e), PacifiCare's implementation log stated in the "Action Taken" column: "Ack letters sent to members and providers." (Exh. 811, p. 7628.)

e. For Regulation 2695.5, subdivision (e), PacifiCare's implementation log stated in the "Action Item" column: "find out whether for non-participating provider claims, the ack letters are sent to providers and members." (Exh. 811, p. 7628.)

514. Internal PacifiCare documents reflect that the company intended in 2004 to send acknowledgment letters to providers.

a. A February 18, 2008, e-mail from Lois Norket regarding the "QicLink Acknowledgment Letter History" stated: "I contacted Jenny B. Cheng about the project in 2004. She said the intent was to create an ack letter to the provider however it was probably Pam Eddy's responsibility to turn on the function in the system." (Exh. 729.)

515. PacifiCare intended, but failed, to send acknowledgment letters to providers in 2004 because the company incorrectly set up its claim system.

a. A parameter in the RIMS setup contained an "N" instead of the "Y" that was required to generate acknowledgment letters. (Exh. 729 ["She was unsure why this wasn't done or caught in testing. Failure to set the field from 'N' to 'Y' was obviously an oversight."]; Exh. 727, p. 2408 [reflecting "Acknowledgment Letter Criteria and Text Maintenance" with an "N" to the right of "Provider Letter"]; RT 10120:20-10121:5 (Berkel).)

b. PacifiCare did not catch this error in testing. (Exh. 729 ["She was unsure why this wasn't done or caught in testing."].)

516. Senate Bill 634 ("SB 634") was enacted in 2005, which added section 10133.66, subdivision (c) to the Insurance Code.

517. At that time, PacifiCare analyzed the bill and determined that section 10133.66, subdivision (c) requires insurers to send letters acknowledging the receipt of claims to providers.

a. PacifiCare generated implementation logs for SB 634 setting forth PacifiCare's understanding of what the bill required and what actions the company needed to take to comply with that bill. (Exh. 5316; Exh. 812; RT 8891:12-8892:8; 8893:18-8894:19 (Monk).)

b. PacifiCare's implementation log for SB 634 reflect PacifiCare's understanding that section 10133.66, subdivision (c) requires the company to send to the

provider an acknowledgment letter stating that the company received the claim. It states: "An acknowledgment letter stating we received the claim must be sent to the provider." (Exh. 812, p. 7797.)

c. Another version of PacifiCare's implementation log for SB 634 reflect PacifiCare's understanding that section 10133.66, subdivision (c) requires the company to acknowledge the receipt of claims via the same method of receipt of the claims. It states: "the provider needs to be able to confirm via same method of receipt of the claim." (Exh. 5316, p. 7534; RT 9322:12-25 (Monk).)

518. Legislative history for SB 634 states that the bill "[r]equires insurers to acknowledge receipt of a claim, in the same manner as the claim was received, within 15 working days of the date of receipt." (Exh. 5679, pp. 109, 159 of 310; Exh. 684, p. 2 of 4.)

b. **PacifiCare's Representations During the 2007 MCE**

519. PacifiCare's September 20, 2007, response to a CDI referral provided incorrect information about the reason the company could not produce data on acknowledgment letter dates. (See CDI OB, part IV.H.2.b.)

a. CDI had requested that PacifiCare produce data on the dates that the company acknowledged the receipt of claims processed during the MCE review period. (RT 11573:13-19 (David); Exh. 110, p. 4828 ["The field 'date ack letter sent' was requested by the Department to be included, but is not available for reporting at this time."]; RT 10000:9-15 (Berkel).)

b. PacifiCare responded to this request on September 20, 2007, that those dates were "not available at this time" because the "date acknowledgment letters are sent out are not tracked in RIMS, and have to be queried manually. At this time, if the Department chooses to have this information, it can be only provided on an individual claim basis." (Exh. 110, p. 4828; RT 633:14-634:14 (Vandepas).)

c. Ms. Norket testified that this response informed CDI that "there were acknowledgment letters but that PLHIC cannot provide the data — cannot provide the date of acknowledgment of the letter on an automated basis." (RT 2393:3-8 ["Q. [By Mr. Strumwasser] Now, do you read this response to say that there were acknowledgment letters but that PLHIC cannot provide the data — cannot provide the date of acknowledgment of a letter on an automated basis? Is that a fair reading of this in your understanding? A. Yes."].)

d. The reason PacifiCare could not produce to CDI those data was that PacifiCare was not sending acknowledgment letters during the MCE review period. (Exh. 113, p. 9893; Exh. 118, p. 3427.)

e. PacifiCare's September 20, 2007, response failed to disclose to the Department that acknowledgment letters were not being sent during the MCE review period. (Exh. 110, p. 4828.)

520. PacifiCare intentionally failed to disclose to CDI a known "gap" in the company's process for sending out acknowledgment letters. (See CDI OB, part IV.H.2.b.)

a. On September 19, 2007, the day before PacifiCare's September 20, 2007, response described above, PacifiCare had discovered a "gap" in its process for sending out acknowledgment letters. (Exh. 1139, p. 9768 ["It appears that we may have a gap in the current process that will need to be addressed so that ack letters are sent out consistently."].)

b. PacifiCare decided not to disclose that gap to CDI, but instead to indicate that the data is not available for reporting. PacifiCare decided to disclose the gap if CDI "probes further." (Exh. 1139, p. 9767 ["At this point I would rather not disclose the gap in our process for sending out ack letters, but simply indicate that this data is not available for reporting. If the CDI probes further we can disclose the below information."].)

521. PacifiCare's October 16, 2007, response to a CDI referral incorrectly represented the dates that the company was out of compliance with section 10133.66, subdivision (c). (See CDI OB, part IV.H.2.b.)

a. CDI issued a referral dated October 12, 2007, requesting that PacifiCare "[p]rovide a description of the measures taken to ensure compliance with CIC § 10133.66(c)." (Exh. 113; RT 642:17-643:5 (Vandepas).)

b. In response to that referral, PacifiCare admitted on October 16, 2007, that acknowledgment letters were not being printed from July 2006 until January 2007. PacifiCare represented that the failure occurred because its vendor, Duncan, failed to print these letters. (Exh. 113; RT 2340:17-2341:3; 2393:11-22 (Norket); RT 643:15-644:5 (Vandepas).)

c. Those dates were incorrect.

d. PacifiCare did not send provider acknowledgment letters from January 2006, when section 10133.66, subdivision (c) became effective, until March 1, 2008. (RT 7877:12-7878:2 (Berkel).)

e. PacifiCare also failed to send acknowledgment letters to members from August 2006 until March 13, 2007. (RT 4358:2-7 (Oczkowski); RT 11284:15-20; 11203:14-23 (Berkel); see also RT 4352:18-24 (Oczkowski) ["Q. [By Mr. Gee] If PacifiCare had — independent of this document, if PacifiCare had represented to the Department that the acknowledgment letter process — that Duncan had not been sending acknowledgment letters from July 2006 to January 2007, would you agree with that representation? A. No."].)

522. PacifiCare's October 25, 2007, response to a CDI referral provided further false information that PacifiCare was sending acknowledgment letters to providers at that time, when no such letters were being sent. (See CDI OB, part IV.H.2.b.)

a. Based on PacifiCare's representations that acknowledgment letters were being sent as of January 2007, CDI issued a follow-up referral requesting that

PacifiCare produce 10 sample acknowledgment letters of PacifiCare's choosing. (Exh. 115; RT 1086:2-9 (Valenzuela).)

b. PacifiCare responded on October 25, 2007, that it was "unable to provide carbon copies of the letters at this time" and instead provided a "sample letter" created using its template. (Exh. 114; RT 2397:12-2398:3 (Norket).) That sample letter purported to be an acknowledgment letter to a provider, Grossmont Hospital Corporation, dated October 24, 2007. (Exh. 726, p. 7332; RT 10106:4-10107:22 (Berkel).)

c. PacifiCare was not sending any acknowledgment letters to providers during that time.

d. PacifiCare did not send provider acknowledgment letters from January 2006, when section 10133.66, subdivision (c) became effective, until March 1, 2008. (RT 7877:12-7878:2 (Berkel).)

e. PacifiCare also failed to send acknowledgment letters to members from August 2006 until March 13, 2007. (RT 4358:2-7 (Oczkowski); RT 11284:15-20; 11203:14-23 (Berkel).)

523. During the MCE, PacifiCare admitted that it was required to send an acknowledgment letter if a claim was not otherwise acknowledged by payment or issuance of an EOB.

524. PacifiCare admitted that it had violated section 10133.66, subdivision (c) for 81,270 claims.

a. In PacifiCare's December 7, 2007, response to CDI's verified written MCE reports, the company "agree[d] that it is required to send an acknowledgment letter for claims received, if the claim is not otherwise acknowledged by payment and/or issuance of an EOB within 15 calendar days." (Exh. 117, p. 3409; Exh. 118, p. 3427.)

b. In PacifiCare's responses, it admitted that its "acknowledgment letter process was not in compliance for July 2006 through December 2006," and agreed that

it had violated section 10133.66, subdivision (c) for 81,270 claims. (Exh. 117, p. 3409; Exh. 118, p. 3427.)

c. It further represented that "[a]cknowledgment letters for individual claims were corrected in July 2007." (Exh. 117, p. 3409; Exh. 118, p. 3427.)

525. PacifiCare's representations to CDI in the December 7, 2007, company response that the acknowledgment-letter process was corrected in January 2007 and, for individual claims, in July 2007 were not true. (Exh. 117, p. 3409; Exh. 118, p. 3427.)

a. PacifiCare did not send provider acknowledgment letters from January 2006, when section 10133.66, subdivision (c) became effective, until March 1, 2008. (RT 7877:12-7878:2 (Berkel).)

b. PacifiCare also failed to send acknowledgment letters to members from August 2006 until March 13, 2007. (RT 4358:2-7 (Oczkowski); RT 11284:15-20; 11203:14-23 (Berkel).)

526. Based on PacifiCare's representations during the MCE that the period that the company's acknowledgment-letter process was broken was from July 2006 until January 2007, and based on PacifiCare's admissions, CDI alleged in the OSC 81,270 acts in violation of section 10133.66, subdivision (c). (Exh. 1, p. 3524; Exh. 117, p. 3409; Exh. 118, p. 3427.)

c. **PacifiCare's Representations Post-MCE**

527. PacifiCare representatives met with CDI officials in March 2008.

528. At that meeting, PacifiCare provided CDI a written presentation (Exh. 817) that provided confusing and misleading information about the dates of the company's noncompliance with the acknowledgment statute.

a. In that written presentation, PacifiCare also represented that its web portal made the company compliant with section 10133.66, subdivision (c). (Exh 817, p. 6516 ["Compliance with CIC 10133.66 — Acknowledgment Through Provider Portal"]; RT 14641:7-10 (Monk).)

b. That representation is incorrect. Ms. Monk and Ms. Berkel have admitted that the company's web portal does not make PacifiCare compliant with section 10133.66, subdivision (c). (E.g., RT 8029:12-8030:9 (Berkel); RT 14641:20-14642:1 (Monk).)

529. On January 20, 2010, Lois Norket, a PacifiCare claims manager, testified at the hearing that acknowledgment letters were being sent beginning in February 2007:

> "Q. [Mr. Strumwasser:] As far as you know, were acknowledgment letters sent out in February 2007?
> A. That was the understanding that I had." (RT 2433:6-9 (Norket).)

> "Q. To the best of your knowledge, when was the issue of failure to send acknowledgment letters resolved?
> MR. VELKEI: Objection, vague.
> THE COURT: Overruled. Do you understand?
> THE WITNESS: You're referring to actual hardcopy acknowledgment letters, correct?
> MR. STRUMWASSER: Q. Yes.
> A. From my understanding, when this was identified as an issue, they should have started printing and being mailed in February of 2007. That's what I was told." (RT 2437:18-2438:5 (Norket).)

530. Ms. Norket's testimony on this issue was not true.

a. Ms. Norket was aware in February 2008 that provider acknowledgment letters had not been sent at any time from 2004 to February 2008.

b. Ms. Norket was informed on February 18, 2008, that provider acknowledgment letters were not being generated from 2004 to February 2008 because of an "oversight" in the set up in RIMS. (Exh. 729 ["I contacted Jenny B. Cheng about the project in 2004. She said the intent was to create an ack letter to the provider however it was probably Pam Eddy's responsibility to turn on the function in the system. She was unsure why this wasn't done or caught in testing. Failure to set the field from 'N' to 'Y' was obviously an oversight. . . . Spoke to Trizetto who confirmed that provider letter would not generate as system was not set to create a letter to the provider."].)

531. PacifiCare's failure to send member acknowledgment letters was caused by the company refusing to invest in adequate monitoring and tracking tools for its acknowledgment letter process.

a. PacifiCare contends that this failure was caused by the company's outsourcing of printing functions to Duncan Print Services ("Duncan"). (Exh. 113; RT 7706:19-7707:5 (Berkel).)

b. In the transition of these functions to Duncan, PacifiCare was repeatedly told that the company should invest in certain tools, such as Duncan's Print Tracking and Reconciliation System and the CodeLite program. (Exh. 412; Exh. 413; Exh. 415; RT 4339:2-19 (Oczkowski); Exh. 423, p. 5049; RT 4368:20-4369:2 (Oczkowski).) These tools would have allowed PacifiCare to track the documents that were sent to Duncan. (RT 4336:15-4337:21 (Oczkowski).)

c. Duncan employees were unable to find anyone at PacifiCare to work with them to implement these tracking tools. (RT 415, p. 6078; RT 4349:1-16 (Oczkowksi) ["Many people had left PacifiCare. They weren't there anymore. So there was no one there to work with us."].)

d. PacifiCare did not implement those monitoring and tracking tools. (Exh. 415, p. 6078; RT 4379:11-15 (Oczkowski); RT 1064:5-1065:2 (Berkel).)

532. Had PacifiCare implemented those monitoring and tracking tools, the company would have detected the issue with the member acknowledgment letters sooner. (RT 4369:13-21 (Oczkowski) ["We would have caught it sooner, yes."]; Exh. 423, p. 5049.)

d. **Harm Caused by Violations**

533. Failing to send acknowledgment letters causes harm to members and providers.

534. If a provider doesn't receive acknowledgment that a claim has been received, he or she may submit to the payor a duplicate claim, known as a tracer. This practice can be costly to the practice because of the administrative burden of resubmitting the claim.

(RT 17155:10-25 (Wetzel).) It can also result in a health plan denying the claim. (RT 17156:1-8 (Wetzel).)

535. Aileen Wetzel, an Associate Director at the California Medical Association ("CMA") (RT 16627:17-16628:1 (Wetzel)), testified that she has conducted seminars addressing the acknowledgment of claims, in which she explained to providers how the acknowledgment process should work, and how they could use acknowledgment letters in their practice. (RT 17152:22-17154:14 (Wetzel).)

536. An acknowledgment letter affirmatively "confirms that the payor has received the claim so that the physician and his or her staff are not spending their time and effort, wasting their time trying to follow up to determine whether or not the claim was received." (RT 17154:15-17155:9 (Wetzel).)

537. The failure to send acknowledgment letters creates administrative burdens for providers and members. Members and providers are forced to track down whether their claims were received by the insurers. Failing to send acknowledgment letters makes it difficult for claimants to determine whether the insurer paid the appropriate interest on late-paid claims. Claimants who have not received acknowledgment that their claim was received may send an additional notice of claim, increasing administrative burdens on the claimants and the insurers. (Exh. 1184, p. 120:11-17.)

538. PacifiCare witness Valerie Bigam, a medical billing administrator at a managed billing services organization, testified that she doesn't want or use acknowledgment letters. (RT 14953:13-14954:12 (Bigam).)

539. Some providers use acknowledgment letters, and some do not.

540. Some providers find receiving acknowledgment letters useful, and some do not.

541. Independent of harm that is caused to claimants, these acts in violation of the law represent harm to the regulatory process. (Exh. 1184, p. 129; RT 21743:23-21744:7 (Kessler).)

e. **PacifiCare's Website and Telephone Number**

542. PacifiCare contended at the hearing that the company was acknowledging the receipt of claims in compliance with section 10133.66, subdivision (c) through its website portal. (RT 7692:8-19, 7694:10-16 (Berkel); Exh. 5252, p. 6949.)

543. That website maintained by PacifiCare did not provide information on the date the claim was received. (RT 14641:17-14642:1 (Monk) ["we determined that the received date of the claim was not visible on the provider portal"].)

544. PacifiCare's website did not provide any information about a claim until that claim was fully adjudicated in RIMS. (RT 8029:12-8030:9 (Berkel).)

545. PacifiCare's website was not accessible to providers that were not contracted with PacifiCare. (RT 8029:12-15 (Berkel).)

546. PacifiCare contended at the hearing that it was acknowledging the receipt of claims in compliance with section 10133.66, subdivision (c) through its telephone number. (RT 7687:15-7688:1; 8024:1-15 (Berkel); Exh. 5252, p. 6949.)

547. PacifiCare did not affirmatively call providers to acknowledge the receipt of claims. (RT 9333:10-14 (Sing); RT 8024:5-15 (Berkel).) In order for a provider to receive information about the status of a claim, he or she would be required to call the PacifiCare telephone number. (RT 9333:10-14 (Sing).)

f. **DMHC Regulation**

548. PacifiCare contended at the hearing that section 10133.66, subdivision (c) should be interpreted to have the same meaning as the DMHC has given to one of its regulations, California Code of Regulations, title 28, section 1300.71, subdivision (c).

549. February 2008 was the earliest that PacifiCare took the position that section 10133.66, subdivision (c) should be interpreted the same as the DMHC regulation is, not to require acknowledgment letters to be sent. (RT 7674:6-7675:16 (Berkel); RT 10194:6-19 (Berkel) ["it took us through February [2008] to come to the conclusion that an acknowledgment letter was not required for PLHIC"]; RT 10197:15-24 (Berkel).)

550. PacifiCare did not rely upon the DMHC regulation or DMHC's interpretation of that regulation in deciding not to send acknowledgment letters to providers at any point from January 2006 to February 2008.

2. Number of Acts in Violation

551. PacifiCare failed to send provider acknowledgment letters from January 1, 2006, when section 10133.66, subdivision (c) became effective, until March 1, 2008. (RT 7877:12-7878:2; 7880:6-9 (Berkel).)

552. PacifiCare failed to send acknowledgment letters to members from August 2006 until March 13, 2007. (RT 4358:2-7 (Oczkowski); RT 11284:15-20; 11203:14-23 (Berkel).)

553. During the MCE review period, PacifiCare received 41,970 group claims that were submitted by providers, that were paper claims, and that were not processed within 15 working days. (RT 10146:4-10; 10147:13-15 (Berkel); Exh. 731, p. 1; Exh. 733; Exh. 1180; Exh. 1181, p. 1.)

554. During the MCE review period, PacifiCare received 13,505 individual claims that were submitted by providers and that were not processed within 15 working days. (RT 10146:16-20; 10147:13-17 (Berkel); Exh. 731, p. 1; Exh. 733; Exh. 1180; Exh. 1181, p. 2.)

555. In total, during the MCE review period, PacifiCare received 55,475 claims that were submitted by providers, that were paper claims, and that were not processed within 15 working days. (Exh. 731, p. 1; Exh. 733; Exh. 1180; Exh. 1181, p. 2; Exh. 5252, p. 6950 [Total Claims Paid (1,119,599)-(Claims Paid within 15 Working Day (1,016,700) + All Other EDI Paid Claims (47,417)) = 55,482].)

556. PacifiCare was required to send an acknowledgment letter for each of these 55,475 claims, but failed to do so.

557. This figure does not include the number of claims PacifiCare did not acknowledge from January 1, 2006, to June 22, 2006, and from June 1, 2007, through February 29, 2008. The number of such claims, which have not been charged, can be estimated. The MCE period covered 342 days. Thus, the average number of claims that

went unacknowledged in violation of section 10123.13, subdivision (c) was 162.21 (55,475/342). The period from January 1 to June 22, 2006, consists of 172 days, and from June 1, 2007 to February 29, 2008 consists of 243 days. A reasonable estimate of the number of unacknowledged claims during these two periods is 67,317 ((172+243)*162.21).

558. During the MCE review period, PacifiCare received 688 group claims that were submitted by members, that were paper claims, and that were not processed within 15 calendar days. (Exh. 1180; Exh. 1181, p. 3; Exh. 731, p. 2 [901 "RIMS Paper After 15 Cal Days No Ack Letter Sent"]; RT 10144:1-15 (Berkel) [901 paper claims paid after 15 calendar days].)

559. During the MCE review period, PacifiCare received 300 group claims that were submitted by members, that were paper claims, and that were not processed within 15 calendar days. (Exh. 732; Exh. 733; Exh. 731, p. 2; RT 10143:6-22 (Berkel); Exh. 1180; Exh. 1181, p. 4.)

560. In total, during the MCE review period, PacifiCare received 988 claims that were submitted by members, that were paper claims, and that were not processed within 15 calendar days. (Exh. 1180; Exh. 1181, pp. 3-4; Exh. 5252, p. 6953 [admitting 1,172 member claims not acknowledged].)

561. PacifiCare was required to send an acknowledgment letter for each of these 988 claims, but failed to do so.

562. In total, there are at least 56,463 acts in violation in evidence.

3. Determination of Penalty

563. The failure-to-acknowledge violations are less serious than the average violation of section 790.03 when compared to violations that, for example, could cause patients to be denied medical care or could result in a failure to timely pay claims. However, failure to acknowledge claims can create administrative burdens for claimants, may make it difficult to determine whether a claim was timely paid or due interest, and can induce a provider to submit duplicate bills, which can increase the administrative burden of claim-processing. (Exh. 1184, p. 120:4-17.)

564. Consistent with this level of severity, such violations justify a unit-penalty 20% of the maximum under section 790.035, or $1,000 per act in violation of section 790.03. (Exh. 1184, p. 120:18-22.)

565. Evidence was presented of mitigation or aggravation pertinent to five of the factors enumerated in Regulation 2695.12, subdivision (a) with respect to the acknowledgment violations.

a. The relative number of claims where the noncomplying acts were found to exist (Reg. 2695.12, subd. (a)(7)) is an aggravating factor. During the MCE period, PacifiCare failed to send any provider acknowledgment letters for paper claims, reflecting a 100% noncompliance rate. PacifiCare failed to send any member acknowledgment letters for approximately 8 of the 11 months reviewed during the MCE, indicating a high noncompliance rate. (Exh. 1184, p. 128:10-18.)

b. PacifiCare did ultimately undertake remedial actions (Reg. 2695.12, subd. (a)(8)) to send out member acknowledgment letters beginning in March 2007 and provider acknowledgment letters beginning in March 2008. With respect to the provider acknowledgment letters, that remedial action was only taken after CDI raised this issue with the company. Although PacifiCare should have discovered the noncompliance earlier than it did and should have taken remedial action more promptly after discovery, the mere fact that remedial actions were eventually taken is a slightly mitigating factor. (Exh. 1184, p. 128:19-26.)

c. There was no evidence that the degree of harm occasioned by PacifiCare's acknowledgment violations (Reg. 2695.12, subd. (a)(10)) was any greater or any less than the harm that would flow from the typical failure to acknowledge claims, so this factor is neither aggravating nor mitigating in this case. (Exh. 1184, p. 129:1-10.)

d. PacifiCare failed to make a good faith attempt to comply with the law (Reg. 2695.12, subd. (a)(11)). PacifiCare made multiple misrepresentations to CDI in an effort to conceal the nature and extent of these violations, reflecting bad faith by the licensee and constituting themselves violations of Regulation 2695.5, subdivision (a). Such lack of candor represents a significant harm to the process, for effective regulation depends in large part on the honesty and forthrightness of licensees. This lack of good faith constitutes a significant aggravating factor. (Exh. 1184, p. 129:10-27.)

e. Failing to send member acknowledgment letters for eight months and provider acknowledgment letters for over two years reflects a high frequency, but there was no evidence of a particularly severe detriment to the public (Reg. 2695.12, subd. (a)(12)). Taken together, this is neither an aggravating nor a mitigating factor. (Exh. 1184, p. 130:1-4.)

f. PacifiCare management should have been aware of the failures to send acknowledgment letters years before the company remediated these issues. (Reg. § 2695.12, subd. (a)(13).) PacifiCare intended to send provider and member acknowledgment letters sometime in 2004 but failed to do so from 2004 through 2005, when, in response to the passage of SB 634, PacifiCare re-examined its policies and procedures with respect to provider acknowledgment letters. At that time, PacifiCare should have detected, but apparently did not detect, that it was failing to send these letters. Then, for almost two years, it failed to detect that provider acknowledgment letters were not being sent out. During the 2007 MCE, in response to a CDI data request, PacifiCare again should have discovered that it was not sending provider acknowledgment letters at that time. That PacifiCare had so many opportunities to discover and then remediate these problems, yet failed to do so, and then failed to take prompt remedial action when management-level staff became aware of the

noncompliance, makes this a significantly aggravating factor. (Exh. 1184, p. 130:5-21.)

g. There was no evidence of mitigating or aggravating circumstances from extraordinary circumstances of these violations (Reg. 2695.12, subd. (a)(1); see Reg. 2695.2, subd. (e)), in the complexity of the claims (Reg. 2695.12, subd. (a)(3)), from PacifiCare's prior compliance record (Reg. 2695.12, subd. (a)(9).)

h. The factors enumerated in subdivisions (a)(2), (a)(4), (a)(5), and (a)(6) do not apply to the claims at issue here.

566. In addition, the evidence of tens of thousands of the same category of acknowledgment violations that the Department has not charged, corresponding to the unacknowledged paper claims from before and after the MCE period, represent additional evidence in aggravation. (Exh. 1184, p. 130:22-28.)

567. Taken together, the evidence of PacifiCare's violations of the acknowledgment requirement are significantly aggravating and justify a 50% upward adjustment to the unit-penalty for this category, resulting in $1,500 per act in violation. (Exh. 1184, p. 130:22-28.)

568. This category of violations presents the circumstance that there is a very large number of violations and the reasonable judgment of the Department that the cumulative gravity of the offenses does not necessarily increase strictly proportionately with the number of violations. (See Exh. 1184, pp. 48:20-49:15.) Mr. Cignarale recommends reducing the unit-penalty by 50% for each group of 50,000 violations after the first 50,000. (Exh. 1184, p. 131:1-6.) PacifiCare, while objecting to Mr. Cignarale's recommended penalty, has not objected to this adjustment, which appears reasonable. Accordingly, the unit-penalty shall be $1,500 for the first 50,000 acknowledgment violations and $750 for violations 50,001 through 56,463.

569. Overall, that results in an average unit-penalty of $1,410 and an aggregate penalty for the category of $79,607,250.

I. Failure to Timely Respond to Provider Disputes

1. PacifiCare's Violations of Law

570. SB 367, which added section 10123.137 to the Insurance Code, was enacted in 2005 and became effective January 1, 2006.

571. While providers could and did submit disputes to PLHIC before the enactment of SB 367, that law established a statutory right to do so and to receive a response to that dispute within a specific time period. (RT 7979:13-7980:1 (Berkel).)

572. In November 2006, CDI began receiving a large number of complaints from providers against PacifiCare. (RT 349:21-350:4; 351:21-352:2 (Masters); Exh. 18.)

a. In early 2007, the CMA filed a complaint against PacifiCare with CDI, alleging a number of contract loading and payment issues. (Exh. 165; Exh. 1019.)

573. PacifiCare's own data demonstrated a significant increase in provider complaints filed with the company around this same time.

a. PacifiCare received no PPO provider disputes in June 2006 and five in July 2006. (Exh. 5046, p. 2229.) In August 2006, that number increased to 226, then to 575 in September, and to 1,205 in October. (Exh. 5046, p. 2229.) The number of provider disputes against the company continued increase, and by May 2007 --- the last month of data provided by PacifiCare --- provider disputes had reached 3,034. (Exh. 5046, p. 2229.)

574. In late 2006, CDI noted a spike in complaints about PacifiCare from providers. (RT 349:21-350:10 (Masters).) Providers contended that they were experiencing "undue delays" in claim reimbursement and underpayments. They also complained of problems with PacifiCare's provider dispute resolution program: "they were spending a lot of time trying to get paid on claims and they were getting nowhere." (RT 351:19-352:2 (Masters); Exh. 18.)

575. Beginning in January 2007, CDI made multiple requests that PacifiCare produce a copy of the company's internal guidelines for processing provider disputes.

a. In a January 30, 2007, e-mail, for instance, PacifiCare acknowledged that "The Department requested information showing compliance with SB367 related to provider grievance process as a result of Dani Collier's January 25, 2007 response to the Department." (Exh. 4, p. 7941.)

b. CDI made another request for these guidelines in February 2007. (Exh. 5, p. 0706 [Agenda #10]; Exh. 7 [see number 10].)

576. PacifiCare provided this information to CDI on June 13, 2007, over four months after CDI first requested it. (Exh. 17, p. 7377; Exh. 5438, p. 4441.)

a. An internal PacifiCare e-mail dated April 30, 2007, revealed that PacifiCare recognized at that time that it needed to make "a number of changes" to its PDR policies and procedures "to be in compliance with the law." (Exh. 749, p. 2283 [number 6].)

b. When PacifiCare provided its provider dispute resolution guidelines to CDI on June 13, 2007, it did not inform CDI that the company's guidelines as of April 30, 2007, were not in compliance. (Exh. 17, p. 7377; Exh. 5438, p. 4441.)

577. During the MCE, CDI examined PacifiCare's provider dispute resolution process and found serious deficiencies, including a high percentage of untimely responses to disputes.

a. CDI reviewed 96 provider dispute files. (Exh. 1, p. 3510.)

b. CDI found that PacifiCare failed to respond within the statutory 45 working days for 14 of those disputes. (Exh. 1, p. 3517.) PacifiCare violated section 10123.137 in over 14% of the files reviewed by CDI.

c. CDI found that PacifiCare failed to respond to several of those provider disputes for many months. (E.g., Exh. 116, pp. 1331 [claim number 19916317, 10-month delay to pay claim]; 1332 [claim number 19079205, over 9-month delay to pay claim]; 1333 [claim number 19116747, over 9-month delay to pay claim]; 1337-1338 [claim

number 19762906-01, 10-month delay to pay claim]; 1345 [19512078-01, 127-day delay].)

d. CDI found a number of instances in which PacifiCare never responded to a provider dispute. (E.g., Exh. 116, pp. 1328-1329 [claim number 4913865-0-9]; 1333 [claim number 19174954]; 1333-1334 [claim number 19452834]; 1339-1340 [claim number 18929522-01].)

e. CDI found instances in which PacifiCare failed to record the receipt date of the provider dispute, making it impossible to track the timeliness of the response. (E.g., Exh. 116, pp. 1322 [claim number 4905006-0-16]; 1344 [claim number 19572969-01].)

578. During the exam, PacifiCare reported that it had received 16,563 provider disputes during the MCE review period, and the company admitted that it failed to respond to 1,510 of these disputes within the statutory 45 working days. (Exh. 1, pp. 3517-3518; Exh. 118, p. 3418; RT 694:24-696:3 (Vandepas).)

579. The evidence in the record demonstrates that PacifiCare's failure to timely adjudicate and respond to provider disputes was caused in significant part by the problems associated with the company's outsourcing of mailroom and routing functions to Lason. (See CDI OB, part IV.I.2.b.)

580. Provider disputes were often misrouted by Lason, causing delays in getting them to the provider dispute resolution department for processing and delays in responding to those disputes.

a. PacifiCare was aware by late 2007 that problems with DocDNA, including the excessive complexity of document-typing rules, were delaying processing of provider disputes. For instance, a weekly DocDNA and REVA issues list updated on September 12, 2007, reported: "Misrouted and missing/lost documents, Medical Records Effecting [sic] TAT's [sic], DOI & PDR findings and provider/member issues" (Exh. 577 [number 2].)

b. Referring to the problem of "documents that arrive late in the Provider dispute resolution unit," Ms. Berkel complained: "we are failing CA law and it is late routing." (Exh. 882, p. 7641.)

c. That same DocDNA and REVA issues list reported that: "There are no documented instructions and procedures that were provided to the Lason India staff to work the Lason intake and REVA Matching Hold Queues. As a result, the TAT's [sic] for the queues was way out of alignment." (Exh. 577 [number 3].)

d. Both provider disputes and the documents sent in support of provider appeals were lost or delayed in DocDNA, and supporting materials were not properly indexed. (Exh. 882, p. 7640; Exh. 728, p. 6699; Exh. 718, p. 4396; Exh. 118, p. 3418; RT 9965:7-14 (Berkel); RT 696:17-697:20 (Vandepas).)

e. When providers submitted medical records that were not attached to a claim, those records were sent to "the undetermined queue within DocDNA." (Exh. 882, p. 7640.) Medical records sent with, or in support of, a provider dispute fell within this queue. This undetermined queue "represent[ed] another stopping point for documents" and "reporting for this queue [was] not well understood." (Exh. 373, p. 0560.)

f. From August 2006 until early 2007, thousands of documents, including provider disputes and supporting material, were "locked" in DocDNA and not uploaded to REVA for processing. (Exh. 341, p. 3978; RT 3273:7-19 (Murray).) PacifiCare acknowledged that the impact of this failure would be "The requirement for CA PPO Provider Disputes to be acknowledged within 15 days and resolved within 45 days will be negatively impacted." (Exh. 341, p. 3978.)

581. The layoffs of the Cypress claims staff in 2006 and subsequent attrition also contributed to PacifiCare's failure to timely respond to provider disputes. (See CDI OB, part IV.I.2.b.)

a. In an October 2, 2007, "Berkel Thoughts" memorandum, Ms. Berkel reported that Ms. Dysinger's provider dispute unit "has been decimated and there is no response. Providers don't know who to go to." (Exh. 717, p. 5404; see also RT 12473:11-15 (Monk) [Dysinger in provider dispute unit].)

b. Provider complaints and written disputes were therefore often referred to Network Management staff . (Exh. 286 [Sept. 28, 2007, 8:55 p.m., e-mail from Harvey to Edberg, others]; Exh. 287, p. 6168 [Mimick 5:05 p.m.].)

c. That staff lacked sufficient expertise to resolve complex billing disputes, and also had also been "reduced through attrition" (Exh. 717, pp. 5404 [bullet 3 under "Background"]) and "had triple work load with the same staff." (Exh. 5265, p. 1948.)

d. As a result, disputes were responded to incorrectly or "upheld without even researching them." (Exh. 717, p. 5404; Exh. 286 [Harvey 8:55 p.m.].)

582. As late as April 2008, PacifiCare was still underperforming with respect to processing provider disputes. A focused audit — which had been initiated in response to CDI's MCE findings (Exh. 355, p. 8504; RT 10235:6-17 (Berkel)) — conducted in April 2008 reported that PacifiCare was erroneously processing provider disputes approximately 25% of the time. (Exh. 741, pp. 6731-6732.)

583. The prompt and accurate payment of claims is of critical importance to providers, but also to patients, insurers, and the overall stability of the health care system. (RT 24237:23-24238:14 (Stead); RT 23231:9-23232:2 (Cignarale); Exh. 1184, p. 132:1-2.)

584. The Legislature, in enacting SB 367, intended to ensure that health care service "be available to Californians without unnecessary administrative procedures, interruptions, or delays." (Legis. Counsel's Dig., Sen. Bill No. 367 (2005-2006 Reg. Sess.) (RON, Exh. H, p. 17).)

585. Insurers' obligation to timely respond to provider disputes is a critical part of the system established by the Legislature to ensure prompt resolution of billing disputes. (Exh. 1184, p. 132:2-4.)

586. As Mr. Cignarale testified, the inability to obtain redress from the 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 cause the Department to be deluged with provider complaints — both representing serious harms. (Exh. 1184, p. 132:2-8.)

587. The harm caused by PacifiCare's violations was worse than the typical case.

588. The evidence reflects that in many instances, PacifiCare was many months — up to 10 months — late in responding to provider disputes.

589. The evidence reflects that in other instances, PacifiCare failed to respond to provider disputes at all.

590. The harm caused by PacifiCare's violations was also aggravated by the company's inadequate customer service. (See CDI OB, part IV.I.2.c.)

591. As Mr. Cignarale testified, when providers experience unwarranted difficulty in obtaining resolution to claim disputes from insurers, they typically either abandon efforts to seek appropriate payment or turn to regulators for assistance. (Exh. 1184, p. 132:4-6.)

a. Providers were forced to spend an inordinate amount of time pursuing review of wrongly denied or improperly adjudicated PLHIC claims, creating significant and unnecessary frustration. (Exh. 1019; RT 2668:14-2669:12; 2674:15-21 (K. Griffin).)

b. This is precisely the type of harm the Legislature intended to avoid by requiring that insurers adopt "a fast, fair and cost-effective dispute resolution mechanism." (§ 10123.137, subd. (a).)

592. The widespread nature of PacifiCare's noncompliance forced CDI to devote significant resources to investigating complaints from providers, which represents a significant harm to the regulatory process. (Exh. 1184, p. 132:6-8.)

2. Number of Acts in Violation

593. During the MCE, PacifiCare admitted that it failed to process 1,510 provider disputes within the statutory 45 working days. (Exh. 1, pp. 3517-3518; Exh. 118, p. 3418; RT 695:25-696:16 (Vandepas).)

594. That number does not include the number of late responses to provider disputes after the MCE review period ended on May 31, 2007.

595. Given the thousands of provider disputes filed in May 2007 (Exh. 5046, p. 2229 [3,034 disputes]) and most certainly after, it is likely there are far more instances in which PacifiCare failed to timely respond to disputes.

596. This 1,510 number also does not include provider disputes to which PacifiCare responded inaccurately or with erroneous requests for information already received.

3. Determination of Penalty

597. Violations of the obligation to timely respond to provider communications regarding disputed claims are moderately serious; less serious than violations that, for example, could cause patients to be denied medical care. However, failure to respond to provider dispute undermines a central feature of the system designed by the Legislature to ensure prompt and accurate claim processing. (Exh. 1184, p. 131:24-132:8.)

598. Based solely on the severity of the violation, and before considering the specific evidence of PacifiCare's violations, Mr. Cignarale recommended placing this violation at 40% of the range from zero to $10,000, or at $4,000 per willful act in violation of section 790.03. (Exh. 1184, p. 132:9-12.)

599. Evidence of mitigation or aggravation was presented pertinent to six of the factors enumerated in Regulation 2695.12, subdivision (a) with respect to the PDR violations.

a. The complexity of provider disputes (Reg. 2695.12, subd. (a)(3) is slightly mitigating, although the regulatory framework accounts for the complexity by permitting insurers 45 working days to respond. (Exh. 1184, p. 135:19-22.)

b. Fourteen instances of noncompliance out of 96 provider dispute files reviewed by CDI is a high relative number of noncomplying acts (Reg. 2695.12, subd. (a)(7)) and an aggravating factor. (Exh. 1184, p. 135:23-25.)

c. Evidence of PacifiCare's remedial measures (Reg. 2695.12, subd. (a)(8)) is both mitigating and aggravating. The company undertook some corrective action, but other measures that the company identified as important, such as adding server space and bringing the processing of provider disputes back in-house, were apparently never implemented. (Exh. 1184, pp. 135:27-136:3.) Taken together, this factor is neither aggravating nor mitigating.

d. The harm occasioned by PacifiCare's failure to respond to provider disputes (Reg. 2695.12, subd. (a)(10)) was worse than in the usual case. PacifiCare's inadequate customer service heightened provider frustration and opportunity costs. Providers were instructed to resubmit disputes because the DocDNA system and other deficiencies prevented customer service staff from informing them whether their written disputes were being processed. The violations also increased the burden on the Department, which expended significant resources addressing provider complaints that should properly have been resolved by the insurer. This is an aggravating factor. (Exh. 1184, p. 136:6-18.) Moreover, PacifiCare did not attempt to achieve the PDR response times it voluntarily committed to in the Undertakings to the Department; concealed from the Department that its provider dispute handling procedures were noncompliant; and misled the Department about the root causes of noncompliance. (Exh. 725, pp. 0835-0836; Exh. 825; Exh. 749, p. 2283; Exh. 358, p. 9596.) These misrepresentations and acts of bad faith harmed the regulatory process.

e. PacifiCare failed to make a good faith attempt to comply with the law (Reg. 2695.12, subd. (a)(11)). Although PacifiCare disclosed the number of provider disputes it received during the market conduct exam and the number it timely adjudicated (Exh. 1184, p. 136:21-22), the company delayed

responding to CDI's request for information about its provider dispute procedure for several months. The company also recklessly implemented a poorly conceived and insufficiently tested document routing process, under which it was foreseeable that the company would misplace provider disputes. (Exh. 1184, p. 136:23-27.)

f. The occurrence of 1,510 violations of this kind over an 11 month period is a high frequency but there was no evidence of a particularly severe detriment to the public (Reg. 2695.12, subd. (a)(12)). Taken together, this is neither an aggravating nor a mitigating factor.

g. PacifiCare's failure to remediate its noncompliant provider dispute process when it was aware or should have been aware of significant deficiencies is an aggravating factor. (Reg. 2695.12, subd. (a)(13).) The company displayed a lack of urgency about addressing the "late routing" it knew to be causing it to "fail CA law." (Exh. 882, p. 7641.) (Exh. 1184, p. 137:12-13.)

h. There was no evidence of mitigating or aggravating circumstances from extraordinary circumstances of these violations (Reg. 2695.12, subd. (a)(1); see Reg. 2695.2, subd. (e)) or from PacifiCare's prior compliance record (Reg. 2695.12, subd. (a)(9).

i. The factors enumerated in subdivisions (a)(2), (a)(4), (a)(5), and (a)(6) do not apply to the claims at issue here.

600. Taken together, the evidence of PacifiCare's violations of the provider dispute requirement are aggravating and justify at least a 10% upward adjustment to the unit-penalty for this category, resulting in $4,400 per act in violation. (Exh. 1184, p. 137:14-18.)

601. This results in an aggregate penalty of $6,644,000, for the 1,510 acts in violation.

J. Illegally Closing or Denying Claims When Requesting Additional Information

1. PacifiCare's Violations of Law

602. From at least December 2005 to sometime in 2007, PacifiCare's practice when it was contesting a claim because it purportedly needed additional information was to "close" or "deny" that claim. (Exh. 23, p. 3090; Exh. 24, p. 3086; Exh. 26, p. 3246; Exh. 30, p. 1045; Exh. 35, p. 1049; Exh. 128, pp. 5095-5098, 5100, 5109, 5123, 5125; Exh. 330, pp. 1-2, 12.)

603. PacifiCare would inform members and providers on EOBs that their claim was being closed or denied due to lack of required information. (RT 8090:18-8091:16 (Berkel); RT 2387:24-2388:19 (Norket).)

604. EOBs dated in 2006 contained a remark code "px" that stated:

> "This claim is being denied due to lack of required information. Please forward the Certificate of Creditable Coverage from your prior carrier. If unavailable, please submit names and addresses of doctors who have treated you in the past year. Refer to your Certificate, 'Exclusionary period for pre-existing conditions.'" (Exh. 23, p. 3090; Exh. 24, p. 3086; Exh. 30, p. 1045; Exh. 35, p. 1049; Exh. 128, pp. 5109, 5123, 5125.)

605. EOBs dated in 2005 to 2007 contained a remark code "iq" that stated:

> "Claim was closed due to lack of response to a prior request for other insurance information. Services will be reconsidered and patient responsibility will be calculated upon receipt. Please refer to your Certificate, 'Payment Responsibility, Right to Receive and Release Information.'" (Exh. 128, pp. 5095-5098, 5100.)

606. 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. (E.g., RT 1017:5-1018:6 (Ms. W); Exh. 128, pp. 5095-5098.)

607. When an insurer requests additional information in order to process a claim, it is contesting — not denying or closing — the claim.

608. Based on complaints against PacifiCare filed with CDI, the Department cited PacifiCare for two violations based on the company's denial of claims using the "px" remark

code when the additional information was being requested. (Exh. 40, p. 4014; Exh. 41, pp. 9454-9455; Exh. 1209, ¶¶ 7, 8.)

609. In those violation letters, CDI explained: "The claim was denied and closed rather than contested or delayed to request additional information such as, a copy of the Certificate of Creditable Coverage or prior Medical Records to properly determine if the claim was for an actual pre-existing condition and not just a potential pre-existing condition. This places an undue burden upon the provider/claimant and the insured to appeal and overcome a denial rather than to provide reasonably necessary information, requested by the insurer to make an informed determination to accept or deny the claim." (Exh. 40, p. 4014; Exh. 41, p. 9454.)

610. Closing and denying claims when an insurer is requesting additional information places an undue burden on the claimant to appeal and overcome a denial.

611. CDI does not have data on the total number of PacifiCare EOBs that closed or denied claims on these bases. Therefore, CDI is alleging 57 acts in violation based on the violation letters, EOBs that are in evidence, and claim spreadsheets indicating "iq" or "px" remark codes. (Exh. 40, p. 4014 [1 citation]; Exh. 41, pp. 9454-9455 [1 citation]; Exh. 23, p. 3090 [1 citation]; Exh. 24, p. 3086 [1 citation]; Exh. 30, p. 1045 [1 citation]; Exh. 35, p. 1049 [1 citation]; Exh. 128, pp. 5095 [1 citation], 5096 [1 citation], 5097 [1 citation], 5098 [1 citation], 5100 [1 citation], 5109 [1 citation], 5123 [1 citation], 5125 [1 citation]; Exh. 127, pp. 1-6 [at least 43 citations]; Exh. 1209, ¶¶ 168-172, 174.)

612. Closing or denying a claim because the insurer claims to need additional information is a wrongful claim denial. That, by itself, represents serious harm.

613. PacifiCare's practice of closing or denying a claim may also cause claimants to be confused about the status of the claim.

614. A claimant receiving notification that a claim is being closed or denied because the insurer needs information may reasonably believe that the insurer's closure or denial of the claim is the insurer's determination on that claim, and many not submit the requested information. (Exh. 1184, p. 138:14-18.)

615. This potential for confusion by claimants also represents serious harm.

616. The language PacifiCare used on its EOBs accompanying the "px" remark code is particularly confusing and may prevent the claimant from submitting the information.

a. It informs the complainant the claim has been "denied."

b. While it instructs the claimant to send in additional information, it does not explain that PacifiCare's denial of the claim will be reconsidered upon receipt of that information.

c. This may create confusion and result in claimants not submitting the requested information because they believe that their claim has been denied.

d. In that instance, the incorrect denial would never be remediated and the claimant will never be properly reimbursed for the claim, resulting in significant harm.

617. The language for the "iq" remark code is particularly confusing and may result in the claimant not submitting the requested information.

a. It states that the claim is closed for lack of response to a prior request for information, even when there has been no prior request for information.

b. It informs the claimant that services will be reconsidered and patient responsibility will be calculated upon receipt of the requested information, but it does not explain what requested information the claimant is being asked to submit.

c. This is very confusing, and similarly may result in the claimant never sending in the requested information. (Exh. 1184, pp. 141:16-142:5.)

2. Number of Acts in Violation

618. The evidence in the record reflects at least 14 PacifiCare EOBs that illegally closed or denied a claim based on PacifiCare's request for additional information.

a. PacifiCare issued an EOB dated July 25, 2006, denying a claim due to lack of required information. (Exh. 23, p. 3090.)

b. PacifiCare issued an EOB dated July 25, 2006, denying a claim due to lack of required information. (Exh. 24, p. 3086.)

c. PacifiCare issued an EOB dated March 27, 2006, denying a claim due to lack of required information. (Exh. 30, p. 1045.)

d. PacifiCare issued an EOB dated March 27, 2006, denying a claim due to lack of required information. (Exh. 35, p. 1049.)

e. PacifiCare issued an EOB dated December 13, 2005 — one day after having received the claim — denying and closing the claim due to lack of required information. (Exh. 40, p. 4014.) This claim was not paid until March 8, 2007. (Exh. 40, p. 4014.)

f. PacifiCare issued an EOB dated April 12, 2006 — eight days after having received the claim — denying and closing the claim due to lack of required information. (Exh. 41, p. 9454.) This claim was not paid until March 20, 2007. (Exh. 41, p. 9455.)

g. PacifiCare issued an EOB dated December 15, 2005, closing a claim due to a lack of response to a prior request for other insurance. (Exh. 128, p. 5095.) This was a claim for date of service December 1, 2005. (Exh. 128, p. 5095.)

h. PacifiCare issued an EOB dated December 15, 2005, closing a claim due to a lack of response to a prior request for other insurance. (Exh. 128, p. 5096.) This was a claim for date of service December 1, 2005. (Exh. 128, p. 5096.) No prior request for insurance had been made; this EOB was the first time PacifiCare had made such a request for insurance. (RT 1017:5-1018:6 (Ms. W).)

i. PacifiCare issued an EOB dated December 15, 2005, closing a claim due to a lack of response to a prior request for other insurance. (Exh. 128, p. 5097.) This was a claim for date of service December 1, 2005. (Exh. 128, p. 5097.)

j. PacifiCare issued an EOB dated December 15, 2005, closing a claim due to a lack of response to a prior request for other insurance. (Exh. 128, p. 5098.)

This was a claim for dates of service December 2 and 3, 2005. (Exh. 128, p. 5098.)

k. PacifiCare issued an EOB dated January 4, 2006, closing a claim due to a lack of response to a prior request for other insurance. (Exh. 128, p. 5098.) This was a claim for date of service December 2, 2005. (Exh. 128, p. 5100.)

l. PacifiCare issued an EOB dated January 12, 2006, denying a claim due to a lack of required information. (Exh. 128, pp. 5109, 5123.) This was a claim for date of service December 3, 2005. (Exh. 128, pp. 5109, 5123.)

m. PacifiCare issued an EOB dated January 20, 2006, denying a claim due to a lack of required information. (Exh. 128, pp. 5125.) This was a claim for date of service December 3, 2005. (Exh. 128, pp. 5125.)

619. Exhibit 127 reflects that PacifiCare issued at least 43 EOBs illegally closing a claim due to a lack of response to a prior request for information, using the remark code "iq." (Exh. 127, pp. 1-6.)

620. In addition, PacifiCare's legal practice of closing or denying claims, by itself, constitutes and act in violation.

621. In total, CDI is alleging 58 acts in violation for PacifiCare illegally closing or denying a claim when it was requesting additional information.

622. Given that PacifiCare followed this practice for at least several years, it is likely that the company issued many more EOBs that illegally closed or denied such a claim.

3. Determination of Penalty

623. This type of violation is of "average seriousness," similar to the wrongful denial of a claim. (Exh. 1184, p. 138:13-18.)

624. Consistent with this level of severity, such violations justify a unit-penalty 50% of the maximum under section 790.035, or $2,500 per willful act. (Exh. 1184, p. 138, p. 21-23.)

625. PacifiCare management's failure to detect and remediate these violations sooner (Reg. 2695.12, subd. (a)(13)) and the lack of evidence that PacifiCare ever took

remedial measures to address these violations (Reg. 2695.12, subd. (a)(8)) were factors in aggravation. (Exh. 1184, pp. 141:12-13; 142:11-15.)

626. The remaining penalty factors are neither aggravating nor mitigating, or are inapplicable to these violations.

627. Taken together, the evidence of PacifiCare's violations for this category are slightly aggravating and justify a 5% upward adjustment to the unit-penalty for this category, resulting in $2,625 per act in violation. (Exh. 1184, p. 142:16-18.)

628. This results in an aggregate penalty of $152,250 for these 58 acts in violation.

K. Sending Untimely Collection Notices on Overpaid Claims

1. PacifiCare's Violations of Law

629. In May 2007, United began integrating PacifiCare's overpayment collection functions into United's Audit Recovery Operations ("ARO") department. (RT 6608:5-10 (Bugiel); Exh. 592, p. 0713.)

630. In January 2008, United assigned several thousand PacifiCare PPO claims to one of United's debt recovery vendors, Johnson & Rountree Premium ("J&R") to collect alleged overpaid amounts on claims. (RT 2955:22-2957:18 (Cassady); Exh. 319.)

a. These claims were known as the PLHIC Historical Claims, and they had been originally paid years before, dating back as far as January 2004. (E.g., Exh. 584, pp. 2 [line 93 reflecting claim paid date of 11/4/04], 3 [line 100 reflecting claim paid date of 12/13/04]; RT 2955:22-2956:18 (Cassady); RT 1240:3-6 (Black).)

631. In January 2008, J&R began sending letters to providers that were designated as "Second Request" letters, which demanded that the providers reimburse PacifiCare for allegedly overpaid amounts on claims. (E.g., Exh. 319, p. 2 [letter date of 01/04/2008]; RT 2972:6-12 (Cassady); Exh. 331, p. 1003 ["Second Request"].)

632. The letters further warned providers: "If a response is not received, PacifiCare may offset future payments by the refund amount requested." (E.g., Exh. 331, p. 1003; Exh. 793, p. 8627.)

633. Many of the overpayment letters that J&R sent on behalf of PacifiCare were untimely and contained incorrect information.

a. One provider, Dr. Mazer, complained to CMA about the demand letter he received on April 8, 2008, requesting repayment of $49.13 on a claim that was initially paid by PacifiCare on October 18, 2005. (Exh. 331, p. 1003; Exh. 592, pp. 0714-0715.)

b. The letter was untimely, sent years after the claim was initially paid.

c. The letter indicated that it was a "Second Request" for repayment. (Exh. 331, p. 1003.) That was incorrect. No first request letter was ever sent. (RT 3043:23-3044:3 (Mazer);

d. PacifiCare admitted that it could not locate a first request letter having been sent to Dr. Mazer on this claim. (Exh. 592, pp. 0714-0715.)

e. The letter identified the overpaid claim as a Secure Horizons claim (Exh. 331, p. 1003), which was wrong (RT 3043:10-22 (Mazer)).

f. PacifiCare admitted that the claim at issue was not for a Secure Horizons member. (Exh. 592, p. 0715.)

g. In response to Dr. Mazer's appeal of this request of reimbursement, PacifiCare withdrew its request for reimbursement on this claim on April 22, 2008. (Exh. 592, p. 0715; Exh. 332.)

h. Dr. Noelle Chiu also complained to the CMA about a demand letter he received from J&R. (Exh. 592, p. 0715.) Dr. Chiu contended that he had previously, on his own, repaid PacifiCare the overpaid amount on that claim. (Exh. 592, p. 0715.)

i. PacifiCare admitted that the provider was correct that he had previously reimbursed the company. (Exh. 592, p. 0715.) PacifiCare admitted that the company's records reflected that the provider's check was cashed on April 17, 2007. (Exh. 592, p. 0715.)

j. Dr. Myron Bloom complained to CDI about an untimely demand letter he received. (Exh. 592, p. 0714.) PacifiCare admitted that it could not locate a timely first request letter, and withdrew its request for reimbursement on this claim. (Exh. 592, p. 0714.)

634. PacifiCare failed to take any measures to verify that a first request letter had been timely sent before instructing J&R to send second request letters. This failure was unreasonable and resulted in J&R sending thousands of untimely overpayment demand letters on PacifiCare's behalf.

a. United believed that PacifiCare had previously sent first request letters on these claims within 365 days of payment. Mr. Bugiel testified that no one at United or PacifiCare verified that such first request letters had been timely sent before having J&R send second request letters. (RT 6721:18-6722:13 (Bugiel).)

b. Ms. Berkel admitted that the company "did not appropriately look for the initial claim overpayment recovery letter before we instructed our vendor, Johnson & Rountree, to initiate a second recovery letter on certain items, on some PLHIC overpayment claim recoveries." (RT 11250:24-11251:3 (Berkel).)

c. At the hearing, J&R employee Jacob Cassady testified that J&R was following instructions from PacifiCare in sending out these collection letters, and that he had assumed that timely first requests had been sent by PacifiCare. (RT 2957:2-12; 2979:6-11 (Cassady); see also RT 6649:19-24 (Bugiel).)

d. It was not until around May-June 2008, after J&R began sending out these "Second Request" letters, that PacifiCare audited the PLHIC Historical Claims to verify that first request letters had been timely sent. (Exh. 592, p. 0715.)

635. In the end of June 2008, PacifiCare had determined that of the 5,224 reimbursement requests sent to providers, 2,912 were "invalid" and needed to be canceled. (Exh. 590, p. 4553.)

636. At that time, PacifiCare had located only several hundred first request letters. (RT 11914:13-22 (Bugiel).)

637. In advance of Mr. Bugiel's testimony on May 13, 2010, PacifiCare again attempted to search its files for additional first request letters. (RT 11891:22-25 (Bugiel).) Mr. Bugiel claimed to have found "hundreds" of additional letters in this search. (RT 11892:5-11 (Bugiel).)

638. At this time, PacifiCare also produced to CDI data that reflected that there were 4,831 PacifiCare PPO claims for which J&R sent untimely overpayment demand letters. (Exh. 584, Exh. 586; RT 11892:17-25 (Bugiel).)

639. After his May 2010 testimony, Mr. Bugiel again went back to his office to look for more first request letters on these claims. (RT 11893:18-11894:11 (Bugiel).)

640. Mr. Bugiel returned for further examination on September 22, 2010, claiming to have located thousands of such letters. (RT 11893:23-11894:11 (Bugiel).)

641. Based on Mr. Bugiel's analysis reflected in Exhibit 5392, the company admitted that there were 1,934 claims for which PacifiCare either was unable to find a first request letter or had sent an untimely first request letter. (Exh. 5392, p. 1645 [1,374 "Remaining Claims" and 560 "Paid Before 1/1/06"]; RT 12715:5-19 (Bugiel).)

642. PacifiCare asserted that 560 of those claims are not violations because they were initially paid before January 1, 2006, when section 10133.66, subdivision (b) became effective. (Exh. 5392, p. 1645; RT 12715:5-19 (Bugiel); see also Exh. 839 [spreadsheet of untimely first request letters].) That is incorrect. PacifiCare sent untimely requests for reimbursement on those 560 claims in 2008, after the statute became effective.

643. PacifiCare contended the data previously produced to CDI mistakenly included 204 non-California claims. (Exh. 5392, p. 1645.) PacifiCare gave no explanation for why incorrect data were produced to CDI.

644. PacifiCare contended that there were 88 claims in those data that were never pursued for overpayment recovery. (Exh. 5392, p. 1645.) PacifiCare offered no explanation for these incorrect data.

645. PacifiCare contended that there were 596 claims that were not pursued for secondary recovery. But PacifiCare did not know whether a first request for recovery had been sent. (Exh. 5392, p. 1645; RT 12712:4-7; 12712:16-19 (Bugiel).)

646. PacifiCare claimed that it found 1,846 first request letters that were timely sent within 365 days of payment of the claim. (RT 12690:3-12 (Bugiel); Exh. 5392, p. 1645.)

647. PacifiCare produced to CDI an Excel spreadsheet that it maintained on these first request letters. (Exh. 836; RT 12678:3-12679:3 (Bugiel).)

648. That spreadsheet contained discrepancies and inaccuracies.

a. The claims data reflected that a number of the first request letters that PacifiCare supposedly found were sent the very same day as the claim was paid. (E.g., Exh. 840, p. 1, lines 6-9, 22-52.) In some instances, the data showed that the first request letter was sent *before* the claim was supposedly initially paid. (E.g., Exh. 840, p. 1, lines 3-5, 10-21.)

b. Mr. Bugiel's explanation was that the dates in the field purporting to be the date that the first request letter was sent may be inaccurate. (RT 12699:17-12700:4 (Bugiel).)

649. Mr. Bugiel admitted that he had no evidence that any of the first notification letters were actually sent on the date reflected in the letter. (RT 12700:5-8 (Bugiel).)

650. This admission casts doubt on each of the 1,846 purported first request letters that PacifiCare has produced and seeks to use to prove that its request was not illegal.

651. PacifiCare asserted that 163 of the alleged violations related to claims that providers voluntarily repaid, so no overpayment letter would have been sent out. (RT 12685:21-12686:4 (Bugiel); Exh. 837; Exh. 5392, p. 1645.)

652. The data on these claims contained discrepancies and inaccuracies.

a. Exhibit 837, which reflects these 163 claims, shows that for nearly all the claims that PacifiCare contended the provider voluntarily repaid, the company recovered no money from the provider and closed the claim in the full amount of the recovery request. (E.g., Exh. 837, p. 1, lines 3, 8, 16-18, 21-23, 27, 30-

45, 47-53 [“Recovered Amount” column blank and “Amount Closed” column equal to “Claim Audit Amount”].)

b. Mr. Bugiel’s explanation for this discrepancy was that the data produced to CDI may be wrong. (RT 12687:4-12688:7 (Bugiel).)

c. The claims data also reflected a supposedly provider initiated claim for which PacifiCare paid commission to a recovery vendor, which obviously would not occur if the provider had initiated the refund. (Exh. 837, p. 1, line 16.)

d. Mr. Bugiel could not say whether or not an overpayment demand letter was issued in that instance. (RT 12688:22-12689:1 (Bugiel).)

e. Mr. Bugiel admitted that it was possible that overpayment letters were in fact sent to providers for these 163 supposed provider initiated claims. (RT 12683:11-12683:16 (Bugiel).)

653. PacifiCare never provided any evidence to explain the inaccuracies in these claims data.

654. In September 2010, PacifiCare produced to the Department around 3,200 pages of documents that purported to be copies of these first request letters that the company had located in 2010. (RT 11903:1-21 (Bugiel).)

655. These documents contained further discrepancies.

a. Many of these letters referenced an attachment, but no attachment was produced. (E.g., Exh. 841, pp. 8627, 8629.)

b. Many of these letters failed to include information required by law to be included on request for reimbursement letters, such as the claim number, the name of the patient, the date of service, and a clear explanation of the basis upon which it is believed the amount paid was in excess of the amount due. (Exh. 842; Exh. 843; Exh. 845; Exh. 847.)

c. Many of these letters also appeared to relate not to PLHIC PPO claims, but to HMO and other non-jurisdictional claims. (E.g., Exh. 841, pp. 8619, 8625.)

656. Following his testimony in September 2010, Mr. Bugiel had another search performed for additional documents associated with the overpayment recovery letters. (Exh. 5531, pp. 1-2, ¶ 2.)

657. In February 2011, PacifiCare produced several hundred more pages of documents, which it contended were the missing attachments to some of the overpayment recovery letters previously produced. (Exh. 5531, p. 2, ¶ 3.)

658. The Department found significant discrepancies that indicated that the purported attachments may not have been attached to the letters at all.

a. Some of the purported attachments had different account numbers than the letters they were supposedly attached to. (Exh. 1002.) Mr. Bugiel couldn't explain that discrepancy. (RT 17093:22-17094:11 (Bugiel).)

b. Some of the purported attachments had different headers and footers than the purportedly corresponding letters. (Exh. 1003; Exh. 1004; Exh. 1005; Exh. 1006.) Mr. Bugiel couldn't explain those discrepancies, either. (RT 17095:23-25 (Bugiel).)

c. Some of the purported attachments were also dated well before or well after the date of the purportedly corresponding letters. (Exh. 1007; Exh. 1008; Exh. 1009; Exh. 1010; Exh. 1011.) Mr. Bugiel also couldn't explain why these dates didn't match. (RT 17103:8-11.)

659. After Mr. Bugiel returned after a lunch break, he testified that he had spoken with Mark Davidson at PacifiCare's overpayment recovery vendor, The Rawlings Company, about the attachment and letter dates not matching. (RT 17127:4-13; 17129:17-21 (Bugiel).) Mr. Bugiel testified that according to Mr. Davidson, Rawlings hadn't been previously imaging attachments to letters, but "some event occurred" in 2007 that caused them to do regenerate and image prior attachments. (RT 17128:22-17129:3; 17129:25-17130:10 (Bugiel). When Rawlings regenerated the prior attachments in 2007, the date was changed, which Mr. Bugiel testified explained the date discrepancies. (RT 17128:22-17129:3 (Bugiel).)

660. Mr. Bugiel's testimony on this issue was not credible.

a. When Mr. Davidson testified, he claimed to have never spoken to or even heard of Mr. Bugiel. (RT 19547:17-19548:20 (Davidson) [After having Mr. Bugiel's name spelled and pronounced three different ways: "THE WITNESS: No, and in none of the three ways does it in any way seem familiar to me."].)

b. Mr. Davidson testified that he did not recall telling anyone from PacifiCare that there was "some event that occurred in 2007 that caused Rawlings to begin imaging the attachments." (RT 19546:13-19 ("A. I don't recall telling anybody from PacifiCare such a thing, no."].)

c. Mr. Bugiel's explanation fails to explain why there are a number of purported attachments whose date precedes the letter date. (E.g., Exh. 1007; RT 17143:5-7 (Bugiel).)

661. Mr. Bugiel admitted that many of the attachments reflected that the company's first request for reimbursement was illegally sent more than 365 days after payment. (RT 17112:12-17113:5 (Bugiel); Exh. 1012.)

662. The purported attachments reflected that PacifiCare had sent an additional 79 untimely demand letters. (Exh. 1013.)

663. In April 2011, PacifiCare filed a declaration of Mr. Davidson. (Exh. 5562.) Mr. Davidson explained that the reason the headers and footers on the letters and attachments didn't match was because the attachment was generated independently of the letter. (Exh. 5562, p. 2, ¶¶ 5-6.)

664. Mr. Davidson admitted that in four instances in which CDI questioned Mr. Bugiel about letter and attachment discrepancies, the attachment that PacifiCare had previously represented was connected to a first request letter was the incorrect document. (Exh. 5562, pp. 2, 5-6, ¶¶ 4, 16, 17, 18; Exh. 1002; Exh. 1014; Exh. 1015; Exh. 1016.)

665. Mr. Davidson asserted that the Rawlings' records confirmed that several of the overpayment letters that CDI had questioned Mr. Bugiel about were in fact generated and sent to the provider on or about the date of the letters. (E.g., Exh. 5562, pp. 2-4, ¶¶ 5, 10, 11,

12.) In several instances, those Rawlings records that Mr. Davidson relied upon in his declaration did not reflect that the letters had been sent, only that they had been printed. (E.g., Exh. 1096, p. 3776; Exh. 1097, p. 3780; Exh. 1101, p. 3797; Exh. 1103, p. 3960; Exh. 1105, p. 3928; Exh. 1107, p. 3920.)

666. On July 22, 2011, Mr. Davidson submitted a supplemental declaration, in which he admitted that three of the first request letters that had previously been produced to CDI, and that PacifiCare had represented were sent to providers, had not been sent to the providers. (Exh. 5613, p. 2, ¶¶ 3-7; Exh. 1108; Exh. 1109; Exh. 1100; Exh. 1111; RT 19499:8-15 (Davidson).)

667. In each of those three instances, a first request letter and attachment had been generated, and they looked identical in format to the other letters and attachments that Rawlings contends were sent. (Exh. 1108; Exh. 1109; Exh. 1100; Exh. 1111.)

668. Mr. Davidson admitted on cross examination that the existence of a copy of an overpayment letter and attachment did not prove that they were in fact sent to a provider. (RT 19592:19-19593:7 (Davidson).)

669. The primary harm caused by untimely overpayment demands is the imposition of administrative burdens on claimants. Sending untimely reimbursement requests can create significant administrative burdens on providers who must track down and review old claims to verify that they were overpaid. (Exh. 1184, p. 143:16-18.)

670. PacifiCare's sending of demand letters on claims that had been paid several years before forced providers to track down several-years-old claims and verify the amounts paid on those claims. (Exh. 1184, p. 152:1-2.) This is extremely burdensome and frustrating for providers. (RT 3051:12-23 (Mazer).)

671. Untimely demands for reimbursement may force providers to collect additional sums from patients years after treatment, which can harm members and adversely affect the doctor-patient relationship. (Exh. 1184, p. 143:18-19.)

672. Untimely reimbursement requests also have a negative financial impact on providers because they are being asked to repay money that they may have already accounted for as revenue. (Exh. 1184, p. 143:19-21.)

673. PacifiCare's data on the overpayment letters reflected that in a significant majority of the instances in which the company had sent an untimely first request overpayment letter, it successfully collected from the provider the full requested amount. (RT 12695:4-12695:10 (Bugiel); e.g., Exh. 839, p. 1, lines 6, 8-37, 39, 45-48, 54 ["Recovered Amount" column reflects full amount of request].)

674. PacifiCare did not repay those amounts illegally collected from providers. Mr. Bugiel admitted that PacifiCare had taken no remedial actions to return those amounts to the providers. (RT 12697:23-12698:11 (Bugiel).)

675. PacifiCare's untimely reimbursement requests, and its failures to properly maintain first request letters, imposed significant administrative on the Department.

676. The Department was forced to examine PacifiCare witnesses for multiple days, to analyze multiple PacifiCare's claims databases, and to review thousands of pages of PacifiCare's documents comprising purported first notice letters, attachments to these letters, and internal records of a PacifiCare recovery vendor — all while this hearing was continuing to proceed.

677. There were significant number of discrepancies in PacifiCare's data and in the documents it produced that Mr. Bugiel, the PacifiCare witness designated as the person most knowledgeable on these issues, was unable to explain. PacifiCare never offered another witness or further evidence to address the many inaccuracies in its data.

678. PacifiCare's processes for data and document retention for these overpayment demands are in disarray. (Exh. 1184, pp. 156:25-157:2.)

679. PacifiCare's claims data relating to these overpayment demand letters are unreliable.

2. Number of Acts in Violation

680. PacifiCare sent untimely overpayment demand letters to providers in at least 1,934 instances.

681. PacifiCare admitted that it sent 1,374 demand letters that were untimely. (Exh. 5392, p. 1645; RT 12715:5-19 (Bugiel).)

682. PacifiCare also admitted that it sent 560 untimely demand letters on claims that were paid before January 1, 2006. (Exh. 5392, p. 1645; RT 12715:5-19 (Bugiel).)

3. Determination of Penalty

683. An insurer's sending of an untimely reimbursement demand represents a "moderately serious" violation; this type of violation can, among other things, create significant administrative burdens on providers, can interfere with the doctor-patient relationship, and can have a negative financial impact on providers. (Exh. 1184, p. 143:12-23.)

684. Consistent with its moderate severity, such violations justify a unit-penalty 30% of the maximum under section 790.035, or $3,000 per willful act in violation. (Exh. 1184, p. 143:26-28.)

685. Evidence was presented of aggravation or mitigation pertinent to the factors enumerated in Regulation 2695.12, subdivision (a) with respect to these untimely overpayment demand violations.

a. There are aggravating circumstances with respect to the remedial measures factor (Reg.2695.12, subd. (a)(8)). Even though PacifiCare canceled the overpayment requests on the claims that it could not find first request letters, PacifiCare failed to take actions to remediate the underlying causes that led to these violations. (Exh. 1184, p. 151:14-16.) Mr. Bugiel's testified that there were no corrective action plans implemented to address the sending of repeated requests for repayment on claims that had already been repaid or to address the sending of second requests in absence of a documentable first request within 365 days. (Exh. 1184, p. 151:16-20.) It is also an aggravating

factor that PacifiCare successfully collected reimbursements from providers based on illegal overpayment requests, yet did not attempt to repay those amounts. (Exh. 1184, p. 151:22-24.)

b. PacifiCare's failure to remediate these issues sooner is also aggravating (Reg. 2695.12, subd. (a)(13). PacifiCare took action only after these illegal overpayment demands were brought to its attention in mid-2008, but, with reasonable diligence, should have detected these problems, including the numerous discrepancies in its data, far sooner. (Exh. 1184, pp. 152:26-153:6.)

c. The harm caused by PacifiCare's violations (Reg. 2695.12, subd. (a)(10)) was a slightly aggravating factor because these overpayment requests related to several-year-old claims, which imposed significant and unnecessary administrative burdens on providers. (Exh. 1184, p. 152:1-2.)

d. Also aggravating was that PacifiCare lacked a good faith attempt to comply (Reg. 2695.12, subd. (a)(11)). Though PacifiCare quickly responded after provider complaints were filed with CDI and the CMA, the company's actions that led to the violations were not taken in good faith. Not verifying that a first request letter was timely sent before sending second request letters is, as Mr. Cignarale noted, "such an obvious omission, especially when the claims are several years old, that I cannot conclude that the company acted in good faith." (Exh. 152, p. 152:13-20.) The unreliability of the company's claims data as evidence of bad faith. (Exh. 1184, p. 152:20-22.) CDI demonstrated at the hearing that the company's flawed data contained so many discrepancies that no reasonable insurer would rely upon them in the conduct of its business.

e. The remaining penalty factors that are applicable are neither aggravating nor mitigating. (Reg. 2695.12, subds (a)(1), (a)(3), (a)(7), (a)(9), and (a)(12).)

686. In light of these factors, it is reasonable to increase the unit-penalty for this category of violations from the generic starting point by 40%, to $4,200 per act in violation. (Exh. 1184, p. 153:7-9.)

687. That results in an aggregate penalty of $8,122,800 for these 1,934 acts in violation. (Exh. 1184, p. 153:9-10.)

L. Failure to Maintain Complete Claim Files

1. PacifiCare's Violations of Law

688. In investigating the complaints filed by members and providers against PacifiCare, CDI compliance officers identified at least 6 instances in which the company failed to maintain important claim-related documents in its files. (Exh. 38, p. 4086 [1 citation]; Exh. 57, p. 8685 [1 citation]; Exh. 79, p. 6318 [1 citation]; Exh. 85, p. 4453 [1 citation]; Exh. 141, pp. 9705-9706 [1 citation]; Exh. 180, p. 3519 [1 citation].)

a. For example, with respect to CSB-6223822, PacifiCare failed to produce the complete claim file even after three separate requests from CDI. CDI only determined that it had not been provided with the complete file because the complainant had submitted claim-related letters from PacifiCare that were missing from PacifiCare's file. (Exh. 180, p. 3519.)

b. With respect to CSB-6232755, PacifiCare was similarly unable to produce the complete claim file, as CDI again discovered that claim-related documents were missing based on a submission by the complainant. (Exh. 141, pp. 9705-9706.)

689. In each instance, CDI sent a violation letter to PacifiCare notifying the company that its failure violated the law. (Exh. 38; Exh. 57; Exh. 79; Exh. 85; Exh. 141; Exh. 180.) PacifiCare did not respond to those letters to contest the violations.

690. During the MCE, PacifiCare admitted that it failed to maintain all documents, notes, and work papers in its claim files in five instances, in violation of Regulation 2695.3, subdivision (a). (Exh. 1, p. 3537.)

691. It also admitted that it failed to maintain documents in its claim files that are accessible, legible, and capable of duplication to hard copy, in violation of Regulation 2695.3, subdivision (b).

692. PacifiCare failed to maintain in its claim files claim dependent documents, such as COCCs. As a result, claims were improperly denied.

693. In the case of Ms. W, PacifiCare failed to maintain a copy of a COCC she had faxed in multiple times. This caused PacifiCare to incorrectly deny her son's claim. (RT 1025:11-1027:3 (Ms. W).)

694. PacifiCare failed to adequately maintain in its claim files copies of overpayment demand letters and data relating to those letters. PacifiCare was unable retrieve such documentation and data for several years. (Exh. 5392, p. 1645; Exh. 837; RT 12690:3-12; 11893:23-11894:11; 12685:21-12686:4 (Bugiel).)

695. PacifiCare's failure to maintain these letters and the data are not being charged in this action, but constitute an aggravating factor for purposes of penalty for this category of violation.

696. One harm caused by an insurer's failure to maintain claim files is that it imposes burdens on the Department, which undermine effective regulation and frustrate the regulatory process. (Exh. 1184, p. 154:15-18.) Such harm is present here.

697. PacifiCare's failure to maintain claim files here caused delays in CDI's regulatory review and in the ultimate resolution of a consumer's complaint.

698. PacifiCare's failure to maintain claim files here resulted in it incorrectly denying claims, which causes serious consumer harm.

2. Number of Acts in Violation

699. PacifiCare committed 15 acts in violation for failing to maintain a complete claim file. (Exh. 38, p. 4086 [1 citation]; Exh. 57, p. 8685 [1 citation]; Exh. 79, p. 6318 [1 citation]; Exh. 85, p. 4453 [1 citation]; Exh. 141, pp. 9705-9706 [1 citation]; Exh. 180, p. 3519 [1 citation]; Exh. 1, pp. 3537-3538 [8 citations]; RT 1025:11-1027:3 (Ms. W) [1 citation].)

3. Determination of Penalty

700. Sending untimely and illegal overpayment recovery letters is a "less serious than average" violation that justifies placing it at 10% of the way from zero to the maximum under section 790.035, or $500 per non-willful act. (Exh. 1184, p. 154:8-23.)

a. Failing to maintain a claim file may cause a claim to be incorrectly processed or to be paid untimely, or may result in increased administrative burdens on claimants who are forced to re-submit information to insurers multiple times. (Exh. 1184, p. 154:11-14.)

b. They may also increase the burdens imposed on the regulator when it must make multiple requests for documents in a claim file, or must investigate a claim based on an incomplete file.

701. For the failure-to-maintain-documents violations that remain in this case, there is no evidence of extraordinary circumstances (Reg. 2695.12, subd. (a)(1)) and no evidence that the claims at issue were complex, or that maintaining the complete claim files for those claims was complex (Reg. 2695.12, subd. (a)(3)).

702. There is insufficient evidence in the record to assess the relative-number-of-claims factor. (Reg. 2695.12, subd. (a)(7).)

703. As to remedial measures taken, PacifiCare contended during the MCE, that it "conducted additional training in October 2007 to address the specific requirements for properly documenting a claim adjudication decision" (Exh. 1, p. 3538), but has offered no evidence demonstrating that such training actually took place or that it effectively remediated PacifiCare's problems. Nevertheless, Regulation 2695.12, subdivisions (a)(7) and (a)(13) will be considered to be factors in mitigation.

704. The degree of harm occasioned by these violations (Reg. 2695.12, subd. (a)(10)) is consistent with that which Mr. Cignarale testified presents in the typical case — incorrectly processed claims, untimely processed claims, and increased administrative burdens on claimants and CDI. (Exh. 1184, p. 154:8-18.) No adjustment is necessary.

705. There is no evidence that under the totality of circumstances, PacifiCare made a good faith attempt to comply (Reg. 2695.12, subd. (a)(11)). This factor is neither aggravating or mitigating.

706. The frequency of the occurrence and/or severity of the detriment to the public as neither aggravating nor mitigating. The number of charged violations is not of a high frequency, though there is evidence in the record or thousands of violations that are not being charged. Further, by imposing burdens on CDI, PacifiCare frustrated the regulatory process and caused detriment to the public.

707. On balance, these factors represent a set of circumstances that are mitigating. This justifies a reduction of no more than 15% of the unit-penalty, from $500 to $425 per act in violation.

708. Based on a unit-penalty of $425, the aggregate penalty is $6,375 for these 15 acts in violation.

M. Failure to Timely Respond to CDI Inquiries

1. PacifiCare's Violations of Law

709. In investigating member and provider complaints against PacifiCare, CDI compliance officers identified at least 29 instances in which the company failed to provide a complete written response to such a CDI inquiry within 21 days.

a. For CSB-6244025, CDI sent PacifiCare a letter dated March 2, 2007, requesting the company's complete responses regarding the status of the claim at issue and a copy of the complete claim file, but PacifiCare's response failed to include the actual bill submitted as well as other claim information. (Exh. 38, p. 4086.)

b. For CSB-6242825, CDI sent PacifiCare a letter dated February 28, 2007, requesting the company's complete responses regarding the status of the claim at issue and a copy of the complete claim file, but PacifiCare's response failed to include copies of the EOBs. (Exh. 41, p. 9453.)

c. For CSB-6232755, CDI sent PacifiCare a letter dated January 2, 2007, requesting the company's complete responses regarding the status of the claim at issue and the complete claim file, but PacifiCare failed to respond within 21 days, failed to provide the complete claim file, and failed to provide a complete response. (Exh. 141, p. 9706.)

d. For CSB-6237500, CDI sent PacifiCare a letter dated January 26, 2007, requesting the company's complete responses regarding the status of the claim at issue and the complete claim file, but PacifiCare failed to provide a complete response within 21 days. (Exh. 185, p. 4485.)

e. For CSB-6233559, CDI sent PacifiCare a letter dated January 25, 2007, requesting the company's complete responses regarding the status of the claim at issue and the complete claim file, but PacifiCare failed to respond within 21 days, failed to provide the compete underwriting file as was requested, and failed to provide a complete response. (Exh. 188, p. 0191.)

f. For CSB-6234573, CDI sent PacifiCare a letter dated February 7, 2007, requesting the company's complete responses regarding the status of the claim at issue and the complete claim file, but PacifiCare failed to provide a complete response within 21 days. (Exh. 190, p. 8697.)

g. For CSB-6244432, CDI sent PacifiCare a letter dated March 7, 2007, requesting the company's complete responses regarding the status of the claim at issue and the complete claim file, but PacifiCare failed to provide a complete response within 21 days. (Exh. 201, p. 9706.)

h. CDI cited PacifiCare at least 22 additional times throughout 2007, 2008, and 2009 for failing to timely respond to CDI inquiries. (Exh. 69, pp. 1449-1450 [1 citation]; Exh. 83, p. 6676 [2 citations]; Exh. 92, pp. 2610-2611 [1 citation]; Exh. 133, pp. 4956-4957 [2 citations]; Exh. 166, p. 1506 [2 citations]; Exh. 169, p. 6341 [2 citations]; Exh. 171, pp. 5347-5348 [2 citations]; Exh. 180, p. 3519 [3 citations]; Exh. 181, p. 0542 [2 citations]; Exh. 182,

p. 8215 [1 citation]; Exh. 184, p. 3139 [1 citation]; Exh. 189, p. 7723 [1 citation]; Exh. 223, p. 9968 [2 citations].)

710. In each instance, CDI sent a violation letter to PacifiCare notifying the company that its failure violated the law. (Exh. 38; Exh. 41; Exh. 69; Exh. 83; Exh. 92; Exh. 133; Exh. 141; Exh. 166; Exh. 169; Exh. 171; Exh. 180; Exh. 181; Exh. 182; Exh. 184; Exh. 185; Exh. 188; Exh. 189; Exh. 190; Exh. 201; Exh. 223.) PacifiCare did not respond to those letters to contest the violations.

711. During the MCE, PacifiCare further admitted that it failed to timely respond to a CDI inquiry in one instance. (Exh. 1, p. 3539.)

712. One of the root causes of these failures was a significant increase in member and provider regulatory complaints being filed against PacifiCare.

a. In March 2007, Dr. Ed Sakamoto, the VP of Clinical Review and Policy (Exh. 671, p. 1544) and the overall head of the member appeals department (RT 14517:3-7 (Cunningham)), reported that "the PPO work increased from 60 to 70 [DOI complaints] to over 200 to a max of 220 in Feb. 07." (Exh. 670, p. 0432; RT 9100:11-17 (Monk).)

b. Dr. Sakamoto noted that the majority of these issues were coming out of California and the Northwest. (Exh. 670, p. 0432.)

c. Ms. Monk admitted at the hearing that the "high volume" of complaints being filed against PacifiCare in the February to April 2007 period adversely affected the company's ability to timely and accurately respond to CDI inquiries. (RT 9106:3-17.)

713. The increase in complaints against PacifiCare was caused by the integration projects implemented by United.

a. Dr. Sakamoto blamed this large number of DOI complaints on United's taking over of PacifiCare's claims, customer service, membership accounting, and the mail room: "Then United took over the PacifiCare Claims shop, Customer

Service, Membership Accounting, and the mail room — all of which generated large numbers of DOI complaints and still do." (Exh. 670, p. 0432.)

b. Katrina Pelto, a Director in PacifiCare's Appeals & Grievances, Regulatory Compliance department, confirmed Dr. Sakamoto's account. She reported in March 2007 that the "PPO team's volume has more than doubled within a year," attributing this twofold increase to the ongoing integration projects implemented by United: "Ongoing transitions of United IT/staffing/work processes are contributing to increase and are not anticipated to decrease." (Exh. 671, p. 1545.)

714. Another root cause for PacifiCare's failures to timely respond to CDI inquiries was that the company was not sufficiently staffed in late 2006 and early 2007 to respond to the increased number of complaints.

a. Dr. Sakamoto noted that in late 2006, before the increase in complaints, "[w]e were understaffed even at that time, but could not hire due to the 'all-in' budget limitations." (Exh. 670, p. 0432.)

715. In a March 21, 2007, e-mail Dr. Sakamoto also complained, "Commercial staff is half of original staff post split with Ovations and the commercial volumes increased dramatically, especially the PPO DOI cases — 91 cases per month to an average of 267 cases per month from 176." (Exh. 671, pp. 1544-1545 [Sakamoto 4:31 p.m.].)

716. PacifiCare further admitted that case research on complaints was "not beginning until day 10-20 after day of receipt," which "leads to increased pressure on other depts. [that the appeals department] rel[ies] on for research, less time for thorough research and investigation." (Exh. 671, p. 1546.)

717. PacifiCare also admitted that the increase in inquiries from regulators was "often due to lack of info provided in [the] first response to DOI" and that the company had "ceased providing feedback on individual cases to various depts. whose error may have caused the complaint in the first place." (Exh. 671, p. 1546.)

718. Failing to timely respond to CDI inquiries that relate to member or provider complaints delays regulatory review and resolution of claims that are being appealed by a member or provider, resulting in harm to members and providers. (Exh. 1184, p. 159:1-3.)

719. As reflected in Regulation 2695.5, timely responding to CDI inquiries is necessary to ensure effective regulation.

720. Delays in responding to CDI inquiries and in providing documentation and claim files requested can significantly frustrate the regulatory process. (Exh. 1184, pp. 159:4-7.)

2. Number of Acts in Violation

721. PacifiCare failed to respond within 21 days to CDI inquiries relating to member and provider complaints in 29 instances. (Exh. 38; Exh. 41; Exh. 69; Exh. 83; Exh. 92; Exh. 133; Exh. 141; Exh. 166; Exh. 169; Exh. 171; Exh. 180; Exh. 181; Exh. 182; Exh. 184; Exh. 185; Exh. 188; Exh. 189; Exh. 190; Exh. 201; Exh. 223.)

722. PacifiCare failed to respond with 21 days to a CDI inquiry during the MCE in one instance. (Exh. 1, p. 3539.)

3. Determination of Penalty

723. Failing to timely respond to CDI inquiries is a "less serious than average" violation. (Exh. 1184, p. 158:26-159:7.)

a. As Mr. Cignarale observed, failing to timely respond to a CDI inquiry may harm members and providers by delaying regulatory review and resolution of a claim that is being appealed, and more generally, by imposing additional burdens on the Department thereby frustrating the regulatory process. (Exh. 1184, p. 159:1-7.)

724. Consistent with its level of severity, such violations justify a unit-penalty at 10% above the maximum under section 790.035, or $500 per non-willful act in violation. (Exh. 1184, p. 159:10-12.)

725. Mr. Cignarale found evidence of mitigation or aggravation pertinent to one of the factors enumerated in Regulation 2695.12, subdivision (a) with respect to these violations.

a. PacifiCare was credited for having a corrective action plan set forth in February 2007 (Reg. 2695.12, subds. (a)(8) and (a)(13)), even though there was no evidence that this plan effectively addressed these failures or that it was ever implemented, for that matter. (Exh. 1184, p. 161:1-3, 161:16-19.)

b. The number of failures at issue was a high frequency, but there was no evidence that the detriment to the public was severe (Reg. 2695.12, subd. (a)(12)), and therefore this factor is neither aggravating nor mitigating. (Exh. 1184, p. 161:11-15.)

c. The remaining 2695.12 factors were neither aggravating nor mitigating, or did not apply.

726. Taken together, the evidence of PacifiCare's violations for this category are slightly mitigating, and justify lowering the unit-penalty by 10%, from $500 to $450 for each act in violation. (Exh. 1184, p. 161:20-22.)

727. This results in an aggregate penalty for these 29 acts in violation of $13,050.

N. Failure to Train Claims Agents on the Fair Claims Settlement Practices Regulations

1. Background

728. PacifiCare's Appeals & Grievances department is responsible for processing appeals of claim adjudications that are filed by members. (RT 1541:16-18 (Mace-Meador); RT 1057:24-1058:12 (Valenzuela).)

729. As of May 2007, it comprised 11 Appeals Coordinators and 3 Appeals Nurses. (Exh. 5046, p. 2222.)

730. Those 14 appeals processors process appeals of claims adjudications that are filed by members.

731. Those 14 appeals processors received training on the Regulations in May 2007. (Exh. 5046, p. 2222.)

732. Prior to May 2007, none of the 14 appeals processors had received training on the Regulations. (RT 1546:2-5 (Mace-Meador).)

a. Ms. Mace-Meador testified that prior to May 2007, no one in the Appeals & Grievances department had received training on the Regulations. (RT 1546:2-5 (Mace-Meador).)

733. PacifiCare's vendor, J&R, handles certain appeals on behalf of PacifiCare. (RT 2924:10-18; 2891:15-2892:7 (Cassady).)

a. The 2007 contract between J&R and PacifiCare provided for J&R to provide appeals handling functions for PacifiCare claims. (Exh. 312, pp. 6-7 of 92, ¶ 4.17.3 ["Appeals Handling/Compliance"].)

b. Mr. Cassady, a business manager at J&R, testified that "whenever Johnson & Rountree is attempting to collect a payment from a provider and the provider disputes the overpayment, Johnson & Rountree functions as the appeals unit of the insurance company." (RT 2924:10-18 (Cassady); see also RT 2891:15-2892:7 (Cassady).)

734. There were nine claims agents in J&R's appeals department. (2896:8-19 (Cassady).)

735. None of these nine claims agents were ever provided training on the Regulations.

a. Mr. Cassady testified that he was unfamiliar with the Regulations himself and did not believe any copies of them existed at J&R's offices. (RT 2926:17-24 (Cassady).)

b. Mr. Bugiel was also unaware if J&R employees had received training on the Regulations. (RT 3732:19-22 (Bugiel).)

736. Failing to provide training on the Regulations is a serious violation that may lead to errors in processing claims.

737. Such errors in processing claims may result in additional violations of law and in harm to members and providers. (Exh. 1184, p. 162:12-13.)

738. Providing such training to claims is a basic requirement that should not be difficult to comply with, and the failure to do so reflects a concerning disregard for clear and unambiguous regulatory requirements. (Exh. 1184, p. 162:13-16.)

2. Number of Acts in Violation

739. PacifiCare failed to provide training on the Regulations to its 14 appeals processors before May 2007.

740. PacifiCare failed to provide training on the Regulations to the nine J&R appeals agents.

741. As of the time Mr. Cassady and Mr. Bugiel testified in 2010, PacifiCare still does not appear to have provided such training.

3. Determination of Penalty

742. Failing to train claims agents is a "very serious" violation. (162:11-18.)

743. Consistent with this level of severity, such violations justify a unit-penalty of 60% of the maximum under the section 790.035, or $3,000 per non-willful act. (Exh. 1184, p. 162:21-23.)

744. Evidence was presented of mitigation or aggravation pertinent to two of the factors enumerated in Regulation 2695.12, subdivision (a) with respect to these failure-to-train violations.

a. The harm caused by these violations was greater than that of a typical case (Reg. § 2695.12, subd. (a)(10)) because the company failed to provide any training, as opposed to providing inadequate training. (Exh. 1184, p. 164:3-6.) PacifiCare also failed to train the entire Appeals & Grievances unit and the entire J&R appeals unit, which as Mr. Cignarale testified, is more serious than failing to train one or a few employees in those units. (Exh. 1184, p. 164:6-7.)

b. The frequency of occurrence and/or severity of the detriment was slightly mitigating. (Exh. 1184, p. 164:15-16.)

c. Mr. Cignarale found no mitigating or aggravating evidence relating to the other 2695.12 factors. (Exh. 1184, pp. 163:20-164:19.)

745. Taken together, the evidence of PacifiCare's violations for this category are slightly aggravating and justify a 10% upward adjustment to the unit-penalty for this category, resulting in $3,300 per act in violation. (Exh. 1184, p. 164:20-22.) That results in an aggregate penalty for this category of $75,900 for these 23 acts in violation. (Exh. 1184, p. 164:20-23.)

O. Misrepresentations to CDI

746. PacifiCare made a number of misrepresentations to CDI during the 2007 MCE. CDI is not seeking separate penalties with respect to those misrepresentations, but is requesting that they be considered as aggravating circumstances in other violation categories.

P. Failure to Conduct Business in Company's Own Name

1. PacifiCare's Violations of Law

747. In investigating consumer complaints against PacifiCare, CDI compliance officers cited the company for 29 acts in violation for failing to conduct business in its own name.

748. PacifiCare failed to identify its legal name on correspondence sent to claimants.

a. For example, for CSB-6240317, PLHIC sent three letters that showed only "PacifiCare" as the underwriting carrier, but nowhere did the company properly identify its legal name, PacifiCare Life and Health Insurance Company, as the licensed insurance company. (Exh. 175, p. 4698.)

b. Such a failure would be confusing to claimants because "PacifiCare" could refer to a number of PacifiCare-related insurance companies, such as PacifiCare of California, PacifiCare Life Assurance Company, PacifiCare Health Systems, PacifiCare Health Plans Administrators, Inc., PacifiCare Behavioral Health, Inc. (E.g., Exh. 5252, p. 6927.)

c. For CSB-6233907, PLHIC sent two letters relating to the claim at issue that mentioned several licensee names but failed to identify PacifiCare Life and Health Insurance Company as the underwriting carrier. (Exh. 183, p. 2171.)

749. PacifiCare failed to identify its legal name on EOBs issued to claimants.

a. For CSB-6223822, PacifiCare sent an EOB to a claimant that failed to identify PacifiCare Life and Health Insurance Company as the underwriting carrier. (Exh. 180, pp. 3518-3519.)

b. For CSB-6295402, PacifiCare sent two EOBs to the claimant that failed to identify PacifiCare as the underwriting carrier, and instead indicated PacifiCare Life Assurance Company as the apparent underwriting carrier. (Exh. 221, p. 0284.)

750. Throughout 2007 and even into early 2008, CDI cited PacifiCare at least 21 additional times for failing to conduct business in its own name. (Exh. 38, p. 4088 [1 citation]; Exh. 134, p. 4235 [5 citations]; Exh. 168, p. 5677 [2 citations]; Exh. 177, p. 4159 [1 citation]; Exh. 193, p. 3416 [1 citation]; Exh. 198, p. 9692 [3 citations]; Exh. 200, p. 9688 [1 citation]; Exh. 201, p. 9706 [1 citation]; Exh. 206, p. 9686 [1 citation]; Exh. 207, p. 6686 [1 citation]; Exh. 220, p. 9806 [1 citation]; Exh. 223, p. 9967 [3 citations].)

751. In each instance, CDI sent a violation letter to PacifiCare notifying the company that its failure violated the law. (Exh. 38; Exh. 134; Exh. 168; Exh. 175; Exh. 177; Exh. 180; Exh. 183; Exh. 193; Exh. 198; Exh. 200; Exh. 201; Exh. 206; Exh. 207; Exh. 220; Exh. 221; Exh. 223.) PacifiCare did not respond to those letters to contest the violations.

752. PacifiCare's failure to conduct business in its own name resulted in member and provider confusion, which is a serious concern. (Exh. 1184, p. 166:14-16.)

753. This failure also may have prevented claimants from filing an appeal with the insurer or with the appropriate regulatory agency, which is a serious concern. (Exh. 1184, p. 166:14-16.)

a. During the time that PacifiCare was sending letters and EOBs that failed to reference its legal name as the underwriting company, it was also failing to

include on its EOPs required notification of the right to appeal to CDI and CDI's contact information.

b. Ms.Wetzel testified that the CMA and its physician members were having difficulty in 2006 and early 2007 determining which regulator to file complaints with because PacifiCare's EOBs and EOPs lacked the required notice and failed to identify the status of the insured. (RT 17178:4-24 (Wetzel).)

754. Identifying the insurer's legal name in business correspondence and EOBs is a basic requirement that should have been easy for PacifiCare to comply with. (Exh. 1184, p. 166:24-25.)

755. PacifiCare's failure to comply with this requirement reflects that the company was not taking such regulatory requirements seriously.

756. PacifiCare's failure to comply with this requirement demonstrates that the company lacked sufficient competence to appropriately run its business.

2. Number of Acts in Violation

757. PacifiCare committed at least 29 acts in violation of section 790.03, subdivision (h)(1) and section 880 by failing to conduct business in its own name. (Exh. 1209, ¶¶ 5, 56, 59, 62, 63, 65, 68, 75, 78, 79, 80, 84, 85, 95, 96, 98.)

3. Determination of Penalty

758. The failure to conduct business using the legal name of the underwriting insurance company is a "less serious than average" violation. (1184, p. 166:13-16.)

759. Based on the severity of the violation, Mr. Cignarale recommended placing this violation at 5% of the range from zero to, in this case, $5,000, or at $250 per non-willful act, for the calculation of the unit-penalty. (Exh. 1184, p. 166:19-21.)

760. There are no mitigating factors under Regulation 2695.12 — no evidence of extraordinary circumstances (Reg. 2695.12, subd. (a)(1); no evidence that the claims involved were complex (Reg. 2695.12, subd. (a)(3); no evidence of mitigation based on the relative number of claims factor (Reg. 2695.12, subd. (a)(7); no evidence of remedial

measures (Reg. 2695.12, subd. (a)(8)); no evidence that PacifiCare made a good faith attempt to comply (Reg. 2695.12, subd. (a)); and no evidence that the frequency of the occurrence and the severity of the detriment was any less than the typical case (Reg. 2695.12, subd. (a)(12)).

761. The number of acts in violation over the course of a two-year period is a higher frequency than normal, which could be an aggravating factor. (Exh. 1184, p. 1184, p. 166:24-26.)

762. Because of PacifiCare's concurrent failures to provide on its EOPs notification of the right to CDI review and CDI's contact information, the harm caused by these violations is likely greater than the usual case.

763. CDI is not seeking aggravation based on the 2695.12 factors.

The per-act penalty for these violations shall be $250, resulting in an aggregate penalty of $7,250 for these 29 acts in violation.

Q. Failure to Timely Respond to Claimants

1. PacifiCare's Violations of Law

764. In investigating the complaints filed by members and providers against PacifiCare, CDI compliance officers identified at least seven instances in which the company failed to provide a complete written response to a communication from a claimant within 15 days.

a. For example, for CSB-6242825, PacifiCare received a facsimile from the claimant on September 14, 2006, but never responded requiring the claimant to call the company about two months later, on November 9, 2006. (Exh. 41, p. 9455.)

b. For CSB-6268720, PacifiCare failed to respond to a provider's request to terminate the contract effective January 1, 2006, until over eighteen months later, on August 31, 2007. (Exh. 56, p. 9178.)

c. PacifiCare further failed to respond to two requests for reconsideration of claims sent by the provider on March 15, 2007, and May 14, 2007. (Exh. 56, p. 9178.)

d. Based on its investigation of consumer complaints, CDI cited PacifiCare at least three additional times for failing to timely respond to claimants. (Exh. 38, p. 4087 [2 citations]; Exh. 218, p. 9673 [1 citation].)

e. In each instance, CDI sent a violation letter to PacifiCare notifying the company that its failure violated the law. (Exh. 38; Exh. 41; Exh. 56; Exh. 218.) PacifiCare did not respond to those letters to contest the violations.

f. During the MCE, CDI further cited PacifiCare for failing to respond to members appeals within 15 days in 11 instances, though those citations are not being charged in this enforcement action. (Exh. 1, p. 3538.)

765. PacifiCare admitted that the results of a December 2008 audit revealed that it failed to fully respond to all the issues in a member appeal in two instances. (Exh. 235; RT 1653:5-9 (Mace-Meador).)

a. PacifiCare admitted that in each of these two cases, the company was "way off in addressing all the issues." (Exh. 235; RT 1653:10-12 (Mace-Meador).)

766. Responding to claim-related communications from claimants should be a high priority for insurers.

767. Failing to timely respond to such communications delays proper processing of claims and delays proper payment of claims, resulting in direct harm to members and providers. (Exh. 1184, p. 167:18-19.)

768. Such delays by insurers also cause frustration and pain and suffering for members and providers. (RT 1040:11-17 (Ms. W); RT 3036:13 (Mazer).)

2. Number of Acts in Violation

769. CDI has charged PacifiCare with nine acts in violation for failing to timely respond to communications with claimants. (Exh. 1209, ¶¶ 5, 8, 17, 93, 185.)

3. Determination of Penalty

770. Mr. Cignarale rated this category of violation as "less serious than average," though he recognized that delays in responding to claimants harms members and providers, and may result in delays in processing claims. (Exh. 1184, p. 167:17-19.)

771. Based on the severity of the violation, he recommended a $1,000 unit-penalty for a typical non-willful violation for failing to timely respond to claimants. (Exh. 1184, p. 167:22-24.)

772. PacifiCare has offered no mitigating evidence for these violations. Indeed, the fact that PacifiCare was still failing providing complete responses to claimants as late as December 2008 could be an aggravating factor under Regulation 2695.12.

773. CDI has not sought aggravation for these violations. Accordingly, the unit-penalty for these violations is $1,000.

774. This results in an aggregate penalty of $9,000 for these nine acts in violation.

R. Failure to Implement a Policy Regarding Recording the Date of Receipt of Claims

1. PacifiCare's Violations of Law

775. Exhibit 224 in evidence reflects a member complaint against PacifiCare filed with CDI in early 2007. (Exh. 224.)

776. The member had complained about PacifiCare's delays in processing two claims. (Exh. 224, p. 2393; RT 1566:22-1567:2; 1573:8-12 (Mace-Meador).)

777. The member had submitted the claims multiple times, but PacifiCare had no record of them. (Exh. 224, pp. 2393, 2394; RT 1566:22-1567:2; 1570:22-1571:2; 1575:10-13 (Mace-Meador).)

778. PacifiCare's employees were confused about what received date to use for one of these claims. (RT 1586:4-9 (Mace-Meador).)

a. Linda Clark, an analyst in the Regulatory Appeals department (Exh. 224, p. 2381), expressed this confusion in a February 20, 2007, to Ms. Mace-Meador. (Exh. 224, p. 2387 [Clark 1:53 p.m.].)

779. PacifiCare's Appeals & Grievances had no policy for determining or documenting the original received date of a claim as of February 20, 2007.

a. Ms. Mace-Meador admitted that as of February 20, 2007, "[w]e did not have as part of our appeals research process specific instructions on documenting or how to determine the original receipt date of the claim. (RT 1589:2-11 (Mace-Meador).)

780. PacifiCare offered no evidence at the hearing indicating that such a policy was ever implemented.

781. The harm caused by not having in place a policy for recording the proper date of receipt of a claim is very serious. (Exh. 1184, p. 168:22-23.)

782. Recording the correct received date of a claim is a fundamental requirement underlying all the provisions of the Insurance Code and Regulations that seek to ensure the prompt payment of claims.

783. If an insurer does not have a consistent policy regarding the recordation of the received date, it calls into question the accuracy of the claims data of that company.

784. PacifiCare's metrics and turnaround times are of questionable accuracy given the lack of a policy on recording the received dates of claims.

785. PacifiCare's reporting pursuant to the Undertakings, specifically with respect to the "Claims processed within 30 calendar day" metric (Exh. 5191, p. 9394), is of questionable accuracy give the lack of such a policy.

786. PacifiCare's lack of such a policy also directly harms claimants by causing claims payment errors. (Exh. 1184, p. 169:2-4.)

787. PacifiCare's practice for rework claims is to use the date the rework request was received as the "received date" in RIMS, and then rely on the claims agents to determine the original received date and to manually change the date in RIMS so that interest would be calculated appropriately. (RT 2368:15-25; 2369:9-16 (Norket).)

788. Without a policy on what received date to use, claims agents in the Appeals & Grievances department wouldn't know what date to use so that interest would be calculated properly.

2. Number of Acts in Violation

789. PacifiCare's failure to adopt and implement a policy for recording the received date of a claim constitutes one act in violation.

790. PacifiCare failed to record the date that a claim was received in one instance. (Exh. 224.)

3. Determination of Penalty

791. The failure to implement a policy regarding recording the date of receipt of a claim represents a "very serious" violation. (Exh. 1184, p. 168:22-169:4.)

792. Consistent with this level of severity, such violations justify a unit-penalty of 65% of maximum under section 790.035, or $3,250 per non-willful act. (Exh. 1184, p. 169:7-9.)

793. PacifiCare has offered no evidence in mitigation for these violations.

794. PacifiCare has provided no evidence that it ever remediated this failure by implementing a consistent policy for its Member & Grievances department, which could be an aggravating factor under Regulation 2695.12, subdivisions (a)(8) and (a)(13).

795. CDI has not sought aggravation for these violations. Accordingly, the unit-penalty for these acts in violation is $3,250.

796. This results in an aggregate penalty of $6,500 for these two acts in violation.

S. Failure to Conduct a Thorough Investigation

1. PacifiCare's Violations of Law

797. Based on CDI's investigation of member and provider complaints against PacifiCare, PacifiCare failed to conduct and diligently pursue investigations into claims in at least 37 instances. (See Exh. 1209, ¶¶ 2, 3, 7, 8, 11, 12, 18, 24, 33, 35, 36, 37, 42, 47, 48, 49, 54, 58, 67.)

a. PacifiCare denied claims based on the *possibility* that the treatment may have been provided for a pre-existing condition, even before the company requested medical records that would have been necessary to adequately investigate and to determine whether the patient had such a pre-existing condition. (E.g., Exh. 29, p. 1032 [7 citations]; Exh. 79, pp. 6317-6318 [1 citation].)

b. PacifiCare continued to request from members and providers medical information that was unnecessary and duplicative, because the information had already been provided. And as a result of PacifiCare's failure to investigate, PacifiCare repeatedly denied these claims improperly. (E.g., Exh. 22, p. 9513 [3 citations]; Exh. 76, p. 8929 [1 citation]; Exh. 48, p. 9388 [3 citations]; Exh. 49, p. 3598 [1 citation]; Exh. 57, p. 8684 [1 citation]; Exh. 166, p. 1506 [4 citations]; Exh. 182, p. 8215 [6 citations]; Exh. 93, p. 2752 [1 citation].)

c. PacifiCare required claimants to re-submit claims multiple times in order to get them processed, in one instance causing an over 10-month delay in getting a claim processed correctly. (Exh. 65, p. 8535 [1 citation]; Exh. 78, p. 6139 [1 citation]; Exh. 102, p. 4588 [1 citation involving a 10-month delay in payment].)

798. Based on CDI's investigation of member and provider complaints, PacifiCare failed to conduct a thorough investigation in at least 6 additional cases throughout 2007, 2008, and 2009. (Exh. 40, p. 4014 [1 citation]; Exh. 41, p. 9455 [1 citation]; Exh. 81, p. 5975 [1 citation]; Exh. 87, pp. 7477-7478 [1 citation]; Exh. 94, p. 9810 [1 citation]; Exh. 95, p. 0057 [1 citation].)

799. In each instance, CDI sent a violation letter to PacifiCare notifying the company that it's failure violated the law. (Exh. 22; Exh. 29; Exh. 40; Exh. 41; Exh. 48; Exh. 49; Exh. 57; Exh. 65; Exh. 76; Exh. 78; Exh. 79; Exh. 81; Exh. 87; Exh. 93; Exh. 94; Exh. 95; Exh. 102; Exh. 166; Exh. 182.) PacifiCare did not respond to contest any of the violations.

800. Based on the testimony of Ms. W, PacifiCare failed to conduct a thorough investigation into claims in 14 instances. (Exh. 1209, ¶¶ 174-178.)

a. Six of those violations related to PacifiCare's illegal practice of closing or denying claims when it was requesting additional information to process the claim, as described in the findings relating to that violation category.

b. Eight of the violations were based on PacifiCare's unnecessary and duplicative requests for additional medical information, such as COCCs and medical records, that had previously been submitted to PacifiCare. (RT 1019:7-1019:23; 1019:24-1020:6; 1026:2-8; 1026:20-1027:10; 1036:11-20; 1038:11-18 (Ms. W).)

801. Based on the testimony of Mr. R, PacifiCare failed to conduct a thorough investigation into claims in two instances. (Exh. 1209, ¶ 179.)

a. PacifiCare required Mr. R to resubmit his claims at least two times after he had initially submitted them.

802. In this case, PacifiCare's failure to conduct a thorough investigation resulted in claims being incorrectly processed, forcing members and providers to submit additional, unnecessary information, to re-submit claims, to file appeals, to file complaints with CDI.

803. This delays claims payment, imposes administrative burdens, and creates significant frustration, as both Mr. R and Ms. W testified about.

804. Failures to conduct and diligently pursue investigations also result in members and providers being denied payment altogether, which can lead patients to be denied medical treatment, because they do not contest the insurers' incorrect adjudications of the claims, or because they give up appealing the insurers' determinations on the claims. (Exh. 1184, pp. 170:23-27.)

2. Number of Acts in Violation

805. PacifiCare failed to conduct and diligently pursue investigations of claims in 52 instances.

806. Six of those acts in violation are being charged as acts in violation based on PacifiCare's illegal practice of closing or denying claims when requesting additional information.

3. Determination of Penalty

807. An insurer's failure to conduct a thorough investigation is very serious. (Exh. 1184, p. 170:19-20.)

808. Based on the severity of the violation, this violation should be placed at 65% of the section 790.035 range, or at $3,250 per non-willful act, for the calculation of the unit-penalty. (Exh. 1184, p. 171:3-5.)

809. PacifiCare has offered no evidence reflecting mitigating circumstances for these violations, and CDI has not sought a finding of aggravation.

810. The per-act penalty for these violations is $3,250.

811. This results in an aggregate penalty of $149,500 for the 46 acts in violation.

T. Misrepresentations of Pertinent Facts

1. PacifiCare's Violations of Law

812. In investigating consumer complaints against PacifiCare, CDI compliance officers cited the company for 80 acts in violation for providing false information to members and providers in the processing of claims and appeals.

a. For example, for CSB-6267035, PacifiCare issued multiple EOBs to the insured and provider that provided misinformation, such as incorrect remark codes and incorrect patient responsibility amounts. (Exh. 22, p. 9513.)

b. For CSB-6252108, PacifiCare sent a letter to the complainant falsely stating that claims had never been received, even though the claim file revealed that the claims had been received at least twice before. PacifiCare also issued an EOB that misinformed the insured that the services exceeded the maximum allowable benefit provision of the policy. (Exh. 48, p. 9388.)

c. For CSB-6268702, PacifiCare issued multiple EOBs that contained misinformation regarding the contract status of the provider, the contract

provider discounts, the amounts payable by PacifiCare, and the patient financial responsibility. (Exh. 53, p. 2884.) PacifiCare sent reconsideration letters that provided the same misinformation. (Exh. 53, p. 2884.)

d. For CSB-6253866, PacifiCare issued multiple EOBs that falsely stated that authorization for services had not been obtained, even though the claim file reflected that authorization for these services had been obtained and was documented in case entry notes and in a letter. (Exh. 55.)

e. For CSB-6279328, PacifiCare issued a denial letter misinforming the claimant that the claims had not been received prior to June 20, 2007. But the claim file included a PacifiCare letter dated April 14, 2007, confirming the receipt of the claims and all information necessary to process the claims. (Exh. 78, pp. 6139-6140.)

f. For CSB-6223822, PacifiCare's customer service representative misinformed the claimant regarding the applicable calendar year maximum during a telephone call on March 10, 2006. PacifiCare acknowledged that this information was incorrect. (Exh. 180, p. 3518.)

813. Throughout 2006, 2007, 2008, and 2009, CDI cited PacifiCare at least 33 additional times for misrepresenting pertinent facts. (Exh. 36 [1 citation]; Exh. 39, p. 2247 [1 citation]; Exh. 49, p. 3598 [14 citations]; Exh. 51, pp. 0667-0668 [4 citations]; Exh. 60, p. 9532 [1 citation]; Exh. 70 [1 citation]; Exh. 72, p. 8878 [1 citation]; Exh. 77 [1 citation]; Exh. 81, p. 5975 [1 citation]; Exh. 85, p. 4453 [1 citation]; Exh. 90 [1 citation]; Exh. 94, p. 9811 [2 citations]; Exh. 133, p. 4956 [1 citation]; Exh. 205, p. 9659[1 citation]; Exh. 207, p. 6686 [1 citation]; Exh. 222, p. 1292 [1 citation].)

814. In each of these instances, CDI sent a violation letter to PacifiCare notifying the company that its misrepresentations violated the law. (Exh. 22; Exh. 36; Exh. 39; Exh. 48; Exh. 49; Exh. 51; Exh. 53; Exh. 55; Exh. 60; Exh. 70; Exh. 72; Exh. 77; Exh. 78; Exh. 81; Exh. 85; Exh. 90; Exh. 94; Exh. 133; Exh. 180; Exh. 205; Exh. 207; Exh. 222.) PacifiCare never responded to contest the citations.

815. PacifiCare made a misrepresentation of a pertinent fact to Mr. R when it incorrectly claimed that it had not received a claim for date of service August 7, 2006, until January 5, 2007. (Exh. 138, p. 9751.) The evidence establishes that that claim was submitted well before January 5, 2007. (Exh. 135, p. 9888; RT 1722:17-21; 1723:21-24 (Mr. R).)

816. PacifiCare made a misrepresentation of a pertinent fact to Mr. R when it denied his claim by EOB dated 9/14/2006 on the ground that it was an uncovered service. (Exh. 140, p. 9721; Exh. 243; RT 1729:10-1730:3; 1733:2-11 (Mr. R).)

817. PacifiCare later admitted that that denial was wrongful. (Exh. 138, pp. 9749-9750; Exh. 140, pp. 9725, 9738.)

818. PacifiCare made a misrepresentation of a pertinent fact to Mr. R when it denied his claim for date of service 8/7/2006 on the ground that the service was "ineligible" for coverage. (Exh. 140, p. 9734; RT 1730:4-20 (Mr. R).)

819. PacifiCare later admitted that that denial was wrongful. (Exh. 138, pp. 9749-9750; Exh. 140, pp. 9725, 9738.)

820. PacifiCare's customer service made a misrepresentation of a pertinent fact to a member that he was enrolled on an HMO plan. That member was actually enrolled on a PPO plan. (Exh. 349, pp. 6625 [Vandeweghe 2:36 p.m.], 6624 [Santillan 2:57 p.m.: "Ryan wasnt [sic] reading the system correctly for HMO"].)

a. PacifiCare Director Marty Sing admitted that the customer service representative gave the member incorrect information. (RT 3373:21-23; 9433:18-9434:3.)

821. PacifiCare's customer service made a misrepresentation of a pertinent fact about whether Social Security numbers are printed on PPO insurance cards. (Exh. 349, p. 6625; RT 9436:17-21 (Sing).)

a. Ms. Santillan told a customer that they were. (Exh. 349, p. 6624 [Santillan 2:57 p.m.: "I was actually unsure if this SSN issue on PPO cards was still happening until recently I received an email with copies of the SSN appearing

in the ID# colum [sic] which was an update by a customer service rep so yes apparantly [sic] this is still happening."].)

b. As Mr. Sing testified, Ms. Santillan was wrong and provided incorrect information to the customer. (RT 9435:22-25; 9437:13-9438:3.)

822. Misrepresentations, when they relate to eligibility, coverage and benefits, may lead to patients deferring needed medical care because they believe it will not be reimbursed. (Exh. 1184, p. 171:18-21.)

823. The evidence demonstrates that such misrepresentations lead to significant delays in claim reimbursements, which can have serious financial consequences for the consumer.

2. Number of Acts in Violation

824. Based on CDI's investigation of member and provider complaints, CDI cited PacifiCare in 80 instances for making misrepresentations of pertinent facts. (See Exh. 1209, ¶¶ 2, 4, 6, 11, 12, 13, 14, 16, 21, 28, 30, 34, 35, 37, 40, 44, 48, 55, 65, 83, 85, 97, 180, 181, 182, 183.)

825. PacifiCare made multiple misrepresentations relating to coverage in the processing of Mr. R's claims, three of which are being charged here. (Exh. 1209, ¶¶ 180-182.)

826. PacifiCare's customer service also made a number of material misrepresentations to customers, two of which are being charged here. (Exh. 1209, ¶ 183.)

3. Determination of Penalty

827. Misrepresentations of pertinent facts or policy provisions are "moderately serious to very serious" violations. (Exh. 1184, p. 171:17-18.) Consistent with that level of severity, such violations warrant a minimum penalty of $1,500 per non-willful act, and for violations that have more severe consequences for consumers, a $3,250 per act penalty. (Exh. 1184, p. 172:5-9.)

828. PacifiCare has offered no evidence in mitigation for these violations. In fact, based on the testimony of Mr. R, PacifiCare has not remediated some of the misrepresentations made to that patient.

829. Despite that aggravating circumstance, and despite the fact that many of these violations did result in severe consequences for consumers, CDI is seeking only the minimum unit-penalty recommended by Mr. Cignarale of $1,500 per non-willful act in violation. That is an appropriate unit-penalty.

830. This results in an aggregate penalty of $127,500 for these 85 acts in violation.

V. AGGREGATE PENALTY

831. In aggregate, the category-by-category penalties deemed above to be appropriate sum to $910,159,088. This is a reasonable aggregate amount, given the gravity and number of the violations in each category.

832. The Department requests that this figure be reduced such that PacifiCare be ordered to pay an aggregate amount of $325 million for all of the violations adjudicated here.

833. It is appropriate to take into account in setting a penalty, in addition to the considerations previously addressed, the respondent's financial condition and ability to pay the penalty.

834. As of June 30, 2011, the most recent date for which there is evidence in the record, PLHIC had $728.8 million in surplus, supporting $221.2 million in net written premium.

835. According to two industry-standard tests, PacifiCare needs between $20.8 million and $73.8 million to support its net written premium. Using the more conservative $73.8 million recommended by the Department, PacifiCare could absorb a penalty of up to $655 million without impairing its ability to function as an insurance company at its most recently reported level.

836. A reduction of the aggregate penalty to $325 million would leave PLHIC with over half of the surplus in excess of the needed amount. That amount would be available to distribute as dividends, subject to the laws generally governing the distribution of dividends.

837. A reduction of the aggregate penalty to $325 million would also correspond to a little more than half the $600.5 million in statutory net income PLHIC recorded in 2006 through 2008, the period corresponding to the activities leading to the violations in this case. That $600.5 million represented a return on surplus of 46.83%, which was more than double the return realized by four comparable insurers, so a $325 million penalty would bring PLHIC's effective return to a figure comparable to its peer companies.

838. An aggregate penalty of $325 million for 908,655 acts in violation of section 790.03 represents an average of $358 per act in violation.

839. An aggregate penalty of $325 million would suffice to provide a credible deterrent to this Respondent and other licensees that find themselves in comparable circumstances. In particular, companies tempted to pursue cost-cutting measures with the knowledge that doing so risked widespread non-compliance with the law would, with the example of a $325 million penalty, be less likely to assume that penalties will be unlikely and, if imposed, will be so small as to make the risk of non-compliance negligible and the cost-cutting a good business decision.

VI. CONCLUSION

840. No findings of fact are being sought here relating to this section of CDI's Opening Brief.

PROPOSED LEGAL CONCLUSIONS

I. INTRODUCTION

1. No legal conclusions are being sought here relating to this section of CDI's Opening Brief.

II. BACKGROUND

2. No legal conclusions are being sought here relating to this section of CDI's Opening Brief.

III. LEGAL FRAMEWORK

A. Section 790.03

3. Section 790.03, subdivision (h) prohibits insurers from "knowingly committing or performing with such frequency as to indicate a general business practice" any of the enumerated unfair claims settlement practices (§ 790.03, subd. (h)(1)-(h)(16)).

4. The "or" in the introductory clause of section 790.03, subdivision (h) is disjunctive, such that the statute prohibits insurers from either knowingly committing any of the enumerated practices or from committing any of the enumerated practices as part of a general business practice. Regulation 2695.1, subdivision (a) is to the same effect.

5. "Knowingly" committing an act under section 790.03, subdivision (h) occurs when the actor has actual, implied, or constructive knowledge, including knowledge implied by operation of law.

6. The function of "frequency" in the section 790.03, subdivision (h) phrase "committed with such frequency as to indicate a general business practice" is to support the inference of a general business practice. In cases where the existence of the general business practice is clear independent of the frequency of acts observed (such as when the insurer has affirmatively stated its practice or where the practice is embedded in a template or program), a single act may have been taken pursuant to a general business practice. In other cases, the number of acts that constitute sufficient frequency to indicate a general business practice will depend on the circumstances.

7. Section 790.03, subdivision (h)(1) prohibits insurers from "misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages at issue." (§ 790.03, subd. (h)(1).) A misrepresentation may consist of an affirmative statement or omission of a material fact where there is a duty to disclose that fact.

8. For purposes of section 790.03, a "claimant" is a first or third party claimant, and a provider submitting a claim is a beneficiary of the policy and thus a first party claimant.

9. Section 790.03, subdivision (h)(2) prohibits insurers from "[f]ailing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies." What constitutes "reasonably promptly" will generally depend on the circumstances, but where the law imposes a duty to act within a specified period, that period defines the maximum time that may constitute "reasonably promptly" under section 790.03, subdivision (h)(2).

10. Section 790.03, subdivision (h)(3) proscribes "[f]ailing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies" as an unfair claims settlement practice. What constitutes reasonable standards will generally depend on the circumstances, but where the law imposes a duty for prompt investigation and processing of a claim within a specified period, that period defines the maximum time for "the prompt investigation and processing of claims."

11. Section 790.03, subdivision (h)(4) prohibits insurers from "failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured." What constitutes "a reasonable time" will generally depend on the circumstances, but where the law imposes a duty to affirm or deny coverage within a specified period, that period defines the maximum time period for "a reasonable time" under section 790.03, subdivision (h)(4).

12. Section 790.03, subdivision (h)(5) proscribes "[n]ot attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear." "Good faith" requires that the actor have harbored an actual and

reasonable belief that it was complying with the law; that the actor was candid in its dealings, did not evince an intent to deceive, and did not desire to gain improper advantage; and that the acts in question have been taken with intent to comply with the actor's legal obligations and without purpose of evading those obligations.

13. What constitutes a prompt attempt to effectuate settlements under section 790.03, subdivision (h)(5) will generally depend on the circumstances, but where the law imposes a duty for prompt investigation and processing of a claim within a specified period, that period defines the maximum time that may constitute "prompt" under subdivision (h)(5). Similarly, the standard for fairness, equity, and reasonable clarity of liability will be informed by other laws prescribing the insurer's duties with respect to claims payment.

14. Where an act is proscribed by section 790.03 in general terms and is also prohibited by another statute, the two statutes should be harmonized and each should, so far as possible, be applied to the act.

15. Violations of the standards of the Fair Claim Settlement Practices Regulations (Reg. 2695 et seq.) are also violations of section 790.03.

B. Section 790.035

16. Under section 790.035, an unfair or deceptive act or practice defined in section 790.03 is subject to a penalty of up to $5,000 per act if not willful, or $10,000 if willful.

17. Section 790.035, subdivision (a) prescribes that "when the issuance, amendment, or servicing of a policy or endorsement is inadvertent, all of those acts shall be a single act for the purpose of this section." Under this provision, multiple acts of servicing a policy arising from a single inadvertence are to be treated as a single act and subject to a single penalty of no more than $5,000 if non-willful or $10,000 if willful. However, the consolidation of multiple inadvertent acts is authorized only if the taking of the act was inadvertent. It does not authorize the consolidation of multiple acts if the decision to service it was not inadvertent but the way in which the servicing was carried out was inadvertent.

18. The inadvertent-servicing provision is subject to a reasonableness limit. If the error was repeated, or persisted for so long that it should have been identified by the company, it does not constitute mere inadvertence but gross negligence, and the consolidation of acts in violation is not warranted under section 790.035, subdivision (a).

19. The distinction in section 790.035, subdivision (a) between willful and non-willful acts is defined by Regulation 2695.2, subdivision (y), which states that the act is "willful" if done or omitted with "a purpose or willingness to commit the act, or make the omission referred to in the California Insurance Code or this subchapter" and "does not require any intent to violate law, or to injure another, or to acquire any advantage."

C. Regulation 2695.12

20. Regulation 2695.12 specifies 14 factors for the Commissioner to consider when determining whether to assess penalties and if so their amount. These factors must be considered if applicable, but they are not exhaustive of the factors the Commissioner may consider in setting a penalty under section 790.035.

21. Regulation 2695.12, subdivision (a)(1) identifies as a factor to be considered in setting a penalty "the existence of extraordinary circumstances." "Extraordinary circumstances" is defined by Regulation 2695.2, subdivision (e) as circumstances outside the control of the insurer that severely and materially affect its ability to conduct normal business operations.

22. Regulation 2695.12, subdivision (a)(3) calls for the Commissioner to consider "the complexity of the claims involved" when assessing penalties. The "complexity" of a claim for purposes of this regulation is determined by comparison to the kinds of claims an insurer writing the kind of insurance it has undertaken to write can reasonable expect to receive. For subdivision (a)(3) to apply, the complexity of the claim must be a causal factor in the noncompliance.

23. Regulation 2695.12, subdivision (a)(7) calls for the Commissioner's consideration of "the relative number of claims where the noncomplying act(s) are found to exist, the total number of claims handled by the licensee and the total number of claims

reviewed by the Department." Where the Department has reviewed a sample of claim files, this regulation prescribes consideration of the relationship of the number of noncomplying acts to the number of files sampled. Where the Department has reviewed all files for compliance with a limited number of laws, the relevant comparison is between the number found to be noncompliant with respect to those laws and the number of files reviewed. Where the Department has reviewed files for compliance with a limited number of laws, it is not appropriate to assume that all files not found to be out of compliance with the laws for which the Department tested are compliant with respect to all laws applicable to those files.

24. In making the comparison prescribed by Regulation 2695.12, subdivision (a)(7) with respect to compliance with a given law, the relevant comparison is the number of noncompliant files to the number of files to which the given law applies and does not consider files to which, under the facts, the law in question does not apply.

25. Regulation 2695.12, subdivision (a)(8) prescribes consideration of "whether the licensee has taken remedial measures with respect to the noncomplying act(s)." This factor can be either mitigating, if remedial measures were taken, or aggravating, if they were not. Remedial measures consist of both retrospective correction of past acts and prospective action to avoid future violations.

26. Remedial action constitutes a mitigating factor under subdivision (a)(8) irrespective of how promptly it was taken.

27. When the noncompliance arose from the company's reliance on the availability of remedial measures to correct the noncompliance, the degree to which those measures operate in mitigation is substantially reduced.

28. Regulation 2695.12, subdivision (a)(9) calls on the Commissioner to consider "the existence or nonexistence of previous violations by the licensee." As a general matter, "the licensee" refers to the entity holding the certificate of authority and not parents or affiliates. However, where the licensee has retained management known to have a history of previous violations, the Commissioner may take that fact into account under subdivision (a)(9).

29. Regulation 2695.12, subdivision (a)(10) provides that the Commissioner shall consider "the degree of harm occasioned by the noncompliance." "Harm" is properly defined to recognize all forms of harm that an insurance company can cause in violating section 790.03 and that should be prevented. This includes not just financial harm but also non-pecuniary harm, such as pain and suffering, inconvenience, and regulatory harm. "Harm" is not limited to out-of-pocket losses and includes injuries that may not be susceptible of quantification.

30. Regulation 2695.12, subdivision (a)(11) calls on the Commissioner to consider "whether, under the totality of circumstances, the licensee made a good faith attempt to comply with the provisions of this subchapter." This factor can function either in aggravation or mitigation. "Good faith" requires that the actor have harbored an actual and reasonable belief that it was complying with the law; that the actor was candid in its dealings, did not evince an intent to deceive, and did not desire to gain improper advantage; and that the acts in question have been taken with intent to comply with the actor's legal obligations and without purpose of evading those obligations.

31. Regulation 2695.12 calls for consideration of "the frequency of occurrence and/or severity of the detriment to the public caused by the violation of a particular subsection of this subchapter." "Frequency" generally refers to the number of claims per policy or other unit of exposure. "[S]everity of the detriment to the public" makes it clear that the measure of severity covers not just the harm to the immediate victim, such as the policyholder (as a member of the public), but also the harm to the general public.

32. Regulation 2695.12, subdivision (a)(13) specifies that the Commissioner consider "whether the licensee's management was aware of facts that apprised or should have apprised the licensee of the act(s) and the licensee failed to take any remedial measures." This factor may be aggravating or mitigating. To be aggravating under subdivision (a)(13), management must have had knowledge of the facts. Unlike subdivision (a)(9), remedial measures taken unreasonably late operate as an aggravating factor. Ineffective attempts at remedial measures are not mitigating.

IV. VIOLATIONS OF LAW AND RECOMMENDED PENALTIES

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

33. Section 10123.13, subdivision (a) and 10123.147, subdivision (a) require insurers to reimburse uncontested claims within 30 working days of receipt. Claims for which PacifiCare had already received COCCs are uncontested claims because the company had the information it needed to process the claims.

34. Regulation 2695.7, subdivision (d) requires insurers to diligently investigate claims and not persist in seeking information not reasonably required to resolve the claim. Each of the 1,799 claims wrongly denied after receipt of a COCC violated this regulation by requesting information already in possession of the insurer.

35. Section 790.03, subdivision (h)(1) prohibits insurers from knowingly or with such frequency as to indicate a general business practice misrepresenting pertinent facts relating to insurance coverage. Each EOB that denied or closed a claim on the basis that the claim was for a pre-existing condition misrepresented the member's policy, which does not exclude such conditions if a member has continuous prior coverage. These EOBs also misrepresented the consumers' obligation to submit a COCC, when in fact they had already done so.

36. Section 790.03, subdivision (h)(3) requires insurers to adopt and implement reasonable standards for the prompt investigation and processing of claims. Each of the 1,799 claims improperly denied for lack of a COCC represents an additional failure to adopt and implement reasonable standards for managing COCCs.

37. Section 790.03, subdivision (h)(5) requires insurers to attempt in good faith to effectuate prompt, fair and equitable settlement of claims in which liability has become reasonably clear. In each of the 1,799 improper denials, PacifiCare's liability was clear as soon as it received the COCC, but it denied the claim instead of attempting in good faith to effectuate prompt payment.

38. PacifiCare knowingly committed these acts in violation, as those terms are used in section 790.03, subdivision (h) and as those terms are defined in Regulation 2695.2, subdivision (*l*).

39. PacifiCare had a general business practice of denying claims and requesting COCCs when COCCs had already been submitted.

40. PacifiCare's improper claim denials related to lost COCCs were willful, as that term is used in section 790.035, subdivision (a) and as that term is defined in Regulation 2695.2, subdivision (y).

41. PacifiCare's improper claim denials related to lost COCCs do not constitute the inadvertent issuance, amendment, or servicing of a policy or endorsement, as those terms are used in section 790.035, subdivision (a).

42. PacifiCare's violations relating to the denial of these claims do not constitute an inadvertent issuance, amendment, or servicing of a policy or endorsement, as that term is used in section 790.035, subdivision (a) and as that term is defined in Regulation 2695.2, subdivision (y).

43. PacifiCare committed 1,799 acts in violation of these statutes and Regulations, by incorrectly denying claims for lack of a COCC.

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

44. For a defined period after a new insurance policy takes effect, insurers are permitted to exclude coverage for "pre-existing" medical conditions — those for which the insured sought treatment or diagnosis during a specified period preceding their enrollment. (§ 10198.6, subdivision (c); 10708.)

45. For plans covering three or more individuals (i.e., group plans), the insurer may exclude coverage of pre-existing conditions for no more than 6 months after the insured's effective date of coverage. (§ 10198.7, subd. (a).)

46. An insurer that denies a group claim based on pre-existing conditions outside this 6-month period violates these sections.

47. Such a denial also violates section 10123.13, subdivision (a) and 10123.147, subdivision (a), which require insurers to reimburse uncontested claims within 30 working days of receipt, because a claim for services after the 6-month period is uncontested and must be reimbursed, not denied.

48. Regulation 2695.4, subdivision (b) requires insurers to disclose all benefits and coverage under the member's policy. Claim denials based on a pre-existing condition exclusionary period longer than 6 months misrepresent the 6-month limitation embedded by law in the member's policy.

49. Section 790.03, subdivision (h)(1) prohibits insurers misrepresenting pertinent facts relating to insurance coverage. Each EOB that denied or closed a claim based on a pre-existing condition outside of the 6-month period constitutes an act in violation of this subdivision, because it misrepresents the member's coverage. It misrepresents to the claimant that the claim is not covered, when it should be. It also misrepresents the period during which PacifiCare is legally permitted to exclude coverage on the basis of pre-existing conditions.

50. Section 790.03, subdivision (h)(3) requires insurers to adopt and implement reasonable standards for the prompt investigation and processing of claims. Each of the 3,862 claims improperly denied on the basis of a pre-existing condition represents a failure to adopt and implement reasonable standards for the processing of claims.

51. Section 790.03, subdivision (h)(5) requires insurers to attempt in good faith to effectuate prompt, fair, and equitable settlement of claims in which liability has become reasonably clear. Each of the 3,862 improper denials constitutes an act in violation of this subdivision because PacifiCare's liability was clear as soon as 6 months elapsed after the member's effective date, but it denied the claim instead of attempting in good faith to effectuate prompt payment.

52. PacifiCare knowingly committed these acts in violation, as those terms are used in section 790.03, subdivision (h) and as those terms are defined in Regulation 2695.2, subdivision (*l*).

53. The Department does not seek a finding of willfulness for these violations. They will be treated as non-willful acts in violation.

54. PacifiCare's improper denials of claims on the basis of pre-existing conditions do not constitute an inadvertent issuance, amendment, or servicing of a policy or endorsement, as those terms are used in section 790.035, subdivision (a).

55. PacifiCare committed 3,862 acts in violation of section 790.03, subdivisions (h)(1), (h)(3), and (h)(5), section 10123.13, subdivision (a), section 10123.147, subdivision (a), section 10708, subdivision (a), section 10198.7, subdivision (a), and Regulation 2695.4, subdivision (b).

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

56. Section 10123.13, subdivision (a) requires insurers to notify providers in writing, within thirty working days after receipt of a claim, if that claim is contested or denied. It requires that notification to advise the provider and insured that either may seek review by CDI of any contested or denied claim, and to include the contact information for the unit within CDI that reviews such complaints.

57. Each EOP informing members that any claimed amount has been denied, in whole or in part, is a "contested or denied claim" within the meaning of section 10123.13, subdivision (a).

58. Each EOP that communicates the insurer's intent to completely deny any claim line constitutes a "denied claim" within the meaning of section 10123, subdivision (a), even if payment is remitted for other claim lines. (RT 25535:17-25536:2 (Stead).)

59. Each EOP that states that part of the billed amount will be paid, and the remainder not paid, is contesting or refuting the insurer's obligation to pay part of the claim. It therefore constitutes a "contested or denied claim" within the meaning of section 10123.13, subdivision (a).

60. PacifiCare's issuance of 462,805 EOPs without CDI review language constitutes 462,805 acts in violation of section 10123.13, subdivision (a).

61. The existence of the right to seek a CDI review is a "pertinent fact" related to coverage within the meaning of section 790.03, subdivision (h)(1).

62. By purporting to disclose the mechanisms available to providers to dispute denied or contested claims, but omitting the information about the right to seek review by the Department, the EOPs misrepresent pertinent facts related to coverage.

63. Each EOP that was sent without notice of the right to CDI review is an act in violation of section 790.03, subdivision (h)(1), which prohibits misrepresentations of pertinent facts related to coverage.

64. Each EOP sent without a notice of CDI review rights constitutes an act in violation of section 790.03, subdivision (h)(3) because misrepresenting rights relevant to securing all benefits owed under an insurance policy reflects a failure to adopt and implement reasonable standards for prompt investigation and processing of claims arising under insurance policies.

65. Each EOP sent without a notice of CDI review rights constitutes an acts in violation of Regulation 2695.7, subdivision (b)(3)

66. PacifiCare knowingly committed these acts in violation, as those terms are used in section 790.03, subdivision (h) and as those terms are defined in Regulation 2695.2, subdivision (*l*).

a. Every one of the 462,479 acts in violation were committed after CDI had given PacifiCare notice of the noncompliance and were, accordingly, knowingly committed. (Exh. 683, p. 9289.)

b. As PacifiCare's expert testified, the company had notice that the omission of CDI review language was a violation of law, as to each of these acts in violation. (RT 24985:11-24986:8 (Stead).)

67. All of the EOPs issued during this time were noncompliant, a frequency indicating a general business practice not to provide the required notice.

68. PacifiCare's general business practice with respect to the giving of notices in the EOPs was to omit notice of the right to appeal to the Department of Insurance, as shown

directly by the form the company used when issuing EOPs and as indicated indirectly by the large number of noncompliant EOPs.

69. PacifiCare's issuance of EOPs without the required CDI review notice does not constitute an inadvertent issuance, amendment, or servicing of a policy or endorsement, as that term is used in section 790.035, subdivision (a) and as that term is defined in Regulation 2695.2, subdivision (y).

70. Each of the acts in violation of the law was willful, as that term is used in section 790.035, subdivision (a) and as that term is defined in Regulation 2695.2, subdivision (y).

a. From February 22, 2007 forward, PacifiCare willingly and purposely misrepresented providers' options for challenging contested or denied claims. PacifiCare deliberately chose to continue issuing EOPs that it knew misrepresented providers' rights for months after it had been informed that its EOPs were illegally omitting this language.

b. Each of the noncompliant acts was performed with knowledge that the act was not in compliance with the law. (Exh. 683, p. 9289.)

71. PacifiCare's committed 462,805 acts in violation of these sections.

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

72. Section 10169, subdivision (i) requires insurers to "prominently display" information concerning the right to request an independent medical review in "copies of insurer procedures for resolving grievances" and in "letters of denial," among other forms.

73. PacifiCare's "Know Your Rights" page, included in each of its EOBs, is a copy of an insurer procedure for resolving grievances within the meaning of section 10169, subdivision (i).

74. Accordingly, IMR information is required to be on each such "Know Your Rights" page of PacifiCare's EOB.

75. Each EOB informing members that the claimed amount has been denied, in whole or in part, is a "letter of denial" within the meaning of section 10169, subdivision (i).

76. Each EOB that that communicates the insurer's intent to deny any claim line constitutes a "letter of denial" within the meaning of section 10169, subdivision (i), even if payment is remitted for other claim lines. (RT 25535:17-25536:2 (Stead).)

77. Each EOB that states that part of the billed amount will be paid, and the remainder denied, is contesting or refuting the insurer's obligation to pay part of the claim. It therefore constitutes a "letter of denial" within the meaning of section 10169, subdivision (i).

78. An EOB that fails to include notification of IMR rights constitutes an act in violation of section 10169, subdivision (i).

79. The existence of the right to seek an IMR for claims denied on the basis of medical necessity is a "pertinent fact" that relates to the member's coverage within the meaning of section 790.03, subdivision (h)(1).

80. By purporting to disclose the mechanisms available to consumers to dispute claim denials, but omitting the information about the right to seek an IMR in certain instances, the EOBs constitute misrepresentations.

81. The sending of each PacifiCare EOB without notice of the right to an IMR is an act in violation of section 790.03, subdivision (h)(1), which prohibits misrepresentations of pertinent facts relating to insureds' coverages.

82. Each EOB sent without a notice of IMR rights from its EOBs constitutes an act in violation of section 790.03, subdivision (h)(3) because misrepresenting rights relevant to securing all benefits owed under an insurance policy reflects a failure to adopt and implement reasonable standards for prompt investigation and processing of claims arising under insurance policies.

83. Each EOB sent without a notice of IMR rights constitutes an act in violation of Regulation 2695.4, subdivision (a).

84. PacifiCare knowingly committed these acts in violation, as those terms are used in section 790.03, subdivision (h) and as those terms are defined in Regulation 2695.2, subdivision (*l*).

85. The number of acts in violation represents such a frequency as to indicate a general business practice, as those terms are used in section 790.03, subdivision (h).

86. From at least March 24, 2007, until June 15, 2007, PacifiCare's general business practice with respect to the giving of notices in the EOBs was to omit notice of IMR rights, as shown directly by the template the company used when issuing EOBs and indirectly by the large number of noncompliant EOBs.

87. PacifiCare's violations for failing to include IMR language on EOBs were willful, as that term is used in section 790.035, subdivision (a) and as that term is defined in Regulation 2695.2, subdivision (y).

a. The omission of IMR language was intentional. (RT 9257:2-13 (Monk).)

b. Each of the noncompliant acts was performed with knowledge that the act was not in compliance with the law. (Exh. 118, p. 3415; Exh. 5303.)

88. PacifiCare's issuance of EOBs without the required IMR notice does not constitute an inadvertent issuance, amendment, or servicing of a policy or endorsement, as those terms are used in section 790.035, subdivision (a).

89. PacifiCare committed 336,085 acts in violation of section 790.03, subdivision (h)(1) and (h)(3), section 10169, subdivision (i), and Regulation 2695.4, subdivision (a).

E. Failure to Timely Pay Claims

90. The stated purpose of AB 4206, enacted in 1986, was to add to the existing Unfair Trade Practices Act, section 790.03 *et seq*., specific time limits for the processing of health claims. (Exh. 1201, p. LIS-9b ["The Unfair Trade Practices Act requires insurers to adopt standards for prompt investigation and processing of claims; failure to do so constitutes an unfair practice subject to administrative, civil or criminal penalties. This bill requires all disability insurers, self-insured employee welfare plans, health care service plans

and nonprofit hospital service plans to pay all nondisputed claims or portions of claims as soon as practical but within 30 working days of submission of the claim. . . .”]; Legis. Counsel’s Dig., Assem. Bill No. 4206 (1985-1986 Reg. Sess.) (RON, Exh. I, p. 28) [“Existing law with respect to policies of disability insurance, self-insured employee welfare benefit plans, nonprofit hospital service plans, and health care service plans does not set a specific time limit for reimbursement of claims made pursuant to the policy or plan. This bill would provide for reimbursement as soon as practical but no later than 30 working days after receipt of the claim”].)

91. Section 10123.13, subdivision (a) added those specific time limits for the processing of health claims, requiring that insurers reimburse all health claims or any portion of any claim as soon as practical but no later than 30 working days after the insurer receives the claim, unless the insurer is contesting or denying the claim or a portion of the claim. That provision also required that the insurer contest or deny health claims within 30 working days of receipt of the claim.

92. For purposes of calculating the 30 working days set forth in section 10123.13, subdivision (a), the date of receipt of the claim is when the insurer first receipts the claim, not when the insurer initiates a rework of a claim.

93. Section 10123.13, subdivision (a) did not make the UIPA (also referred to as the Unfair Trade Practices Act) inapplicable to health claims.

94. In enacting section 10123.13, subdivision (a), the Legislature determined that an insurer that must reimburse, contest, or deny a claim within 30 working days of receipt in order to affirm or deny coverage of claims within “a reasonable time” after receipt, as required by section 790.03, subdivision (h)(4) of the Unfair Trade Practices Act.

95. A violation of the 30-working-day requirement of section 10123.13, subdivision (a) constitutes a violation of section 790.03, subdivision (h)(4), if knowingly committed on a single occasion or performed with such frequency as to indicate a general business practice.

96. In enacting section 10123.13, subdivision (a), the Legislature determined that a insurer must reimburse, contest, or deny claims within 30 working days of receipt in order to act "reasonably promptly upon communications with respect to claims," as required by section 790.03, subdivision (h)(2) of the Unfair Trade Practices Act.

97. A violation of the 30-working-day requirement of section 10123.13, subdivision (a) constitutes a violation of section 790.03, subdivision (h)(2), if knowingly committed on a single occasion or performed with such frequency as to indicate a general business practice.

98. In enacting section 10123.13, subdivision (a), the Legislature determined that an insurer must reimburse, contest, or deny claims within 30 working days of receipt in order to adopt and implement reasonable standards for the "prompt" investigation and processing of claims, as required by section 790.03, subdivision (h)(3) of the Unfair Trade Practices Act.

99. A violation of the 30-working-day requirement of section 10123.13, subdivision (a) constitutes a violation of section 790.03, subdivision (h)(3), if knowingly committed on a single occasion or performed with such frequency as to indicate a general business practice.

100. In enacting section 10123.13, subdivision (a), the Legislature determined that an insurer must reimburse, contest, or deny claims within 30 working days after receipt in order to attempt in good faith to effectuate "prompt," fair, and equitable settlements of claims, as required by section 790.03, subdivision (h)(5) of the Unfair Trade Practices Act.

101. A violation of the 30-working-day requirement of section 10123.13, subdivision (a) constitutes a violation of section 790.03, subdivision (h)(5), if knowingly committed on a single occasion or performed with such frequency as to indicate a general business practice.

102. Compliance with PacifiCare's internal turnaround time metrics does not constitute compliance with the law.

103. Section 10123.13, subdivision (b)'s requirement that an insurer pay 10% interest on late-paid claims constitutes a requirement on insurers separate from and

independent of the requirement that insurers reimburse claims as soon as practical but no later than within 30 working days of receipt set forth in section 10123.13, subdivision (a).

104. An insurer that fails to reimburse claims within 30 working days after receipt does not comply with section 10123.13, subdivision (a) by paying interest in accordance with section 10123.13, subdivision (b).

105. Section 10123.13, subdivision (b) does not constitute the sole and exclusive penalty to be imposed on insurers for late-paid claims.

106. There exists no tolerance threshold in section 790.03, subdivisions (h)(2), (h)(3), (h)(4), and (h)(5) and section 10123.13, subdivision (a) that permits insurers to process some percentage or number of claims more than 30 working days after receipt.

107. PacifiCare's purported compliance with its own internally developed metrics does not mean that it has complied with the law or the regulations at issue in this hearing.

108. The tolerance levels set forth in Chapter 14 of the 2011 version of the NAIC Market Regulation Handbook (Exh. 5648) do not apply to this enforcement action.

109. The metrics described in Undertaking 19 of the Undertakings to the California Department of Insurance (Exh. 5191, p. 9394) do not apply to this enforcement action.

110. PacifiCare's compliance with the metrics described in the Undertakings does not constitute compliance with section 790.03, subdivisions (h)(2), (h)(3), (h)(4), or (h)(5) or section 10123.13, subdivision (a).

111. PacifiCare knowingly committed these acts in violation, as those terms are used in section 790.03, subdivision (h) and as those terms are defined in Regulation 2695.2, subdivision (*l*).

112. The thousands of violations for this category represent a frequency that indicates a general business practice, as those terms are used in section 790.03, subdivision (h). (Exh. 1184, p. 110:6-9.)

113. Each of the acts in violation of the law was willful, as that term is used in section 790.035, subdivision (a) and as that term is defined in Regulation 2695.2, subdivision (y).

114. PacifiCare's failures to timely pay claims do not constitute the inadvertent issuance, amendment, or servicing of a policy or endorsement, as those terms are used in section 790.035, subdivision (a).

115. PacifiCare committed 34,997 acts in violation of these sections.

F. Failure to Pay Interest on Late-Paid Claims

116. Section 790.03, subdivisions (h)(2), (h)(3), (h)(4), and (h)(5) require that claims be processed within a reasonable time after they are submitted.

117. Those provisions also require that claims be correctly paid the full amount owed on them, for a claim is not timely paid unless it is timely paid in the full amount.

118. Section 790.03, subdivision (h)(5) requires that insurers attempt in good faith to effectuate settlements of claims that are prompt, fair, and equitable.

119. An insurer that fails to pay the full amounts owed on claims is not attempting in good faith to effectuate fair and equitable settlements of claims, in violation of section 790.03, subdivision (h)(5).

120. In 1989, the Legislature enacted Assembly Bill 865 ("AB 865"), which added to the Insurance Code the requirement that insurers pay interest in the amount of 10% per year on claims paid more than 30 working days after receipt.

121. This requirement to pay interest, which is set forth in section 10123.13, subdivision (b) is separate and independent from requirement to pay claims within 30 working days, which is set forth in section 10123.13, subdivision (a).

122. The interest requirement of section 10123.13, subdivision (b) does not establish an option for insurers to either pay claims within 30 working days or pay claims after 30 working days with statutory interest.

123. An insurer that fails to pay claims within 30 working days violates section 10123.13, subdivision (a) whether or not it pays statutory interest on those claims as required by subdivision (b).

124. An insurer that fails to pay statutory interest on claims paid after 30 working days violates section 790.03, subdivision (h)(5) because it is failing to attempt in good faith to effectuate prompt, fair, and equitable settlements of claims.

125. An insurer that fails to pay statutory interest on claims paid after 30 working days violates section 790.03, subdivisions (h)(2), (h)(3), and (h)(4) because it is not correctly paying claims in their full amount in a reasonable time and in a prompt manner.

126. An insurer that fails to pay statutory interest on claims paid after 30 working days violates section 790.03, subdivision (h)(1). That insurer is underpaying those claims, and is therefore misrepresenting to claimants the correct amount owed on claims.

127. PacifiCare knowingly committed these acts in violation, as those terms are used in section 790.03, subdivision (h) and as those terms are defined in Regulation 2695.2, subdivision (*l*).

128. The thousands of violations for this category represent a frequency that indicates a general business practice, as those terms are used in section 790.03, subdivision (h). (Exh. 1184, p. 116:18-20.)

129. PacifiCare's failures to pay interest on late-paid claims were willful, as that term is used in section 790.035, subdivision (a) and as that term is defined in Regulation 2695.2, subdivision (y).

130. PacifiCare's failures to pay interest on late-paid claims do not constitute the inadvertent issuance, amendment, or servicing of a policy or endorsement, as those terms are used in section 790.035, subdivision (a).

131. PacifiCare committed 5,195 acts in violation of section 790.03, subdivision (h)(1), (h)(2), (h)(3), (h)(4), and (h)(5) and section 10123.13, subdivision (b).

G. Failure to Correctly Pay Claims

132. Inaccurate claims payments, if knowingly committed or performed with such frequency as to indicate a general business practice, violate section 790.03, subdivision (h)(1) because they misrepresent the amount the insurer has agreed to pay for

services under the policy and the amount for which the patient is responsible — both pertinent facts relating to coverages.

133. They also violate section 790.03, subdivision (h)(3) because they reflect failures to adopt and implement reasonable standards for prompt investigation and processing of claims arising under insurance policies.

134. They are also violations of section 790.03, subdivision (h)(5) because they are instances of an insurer not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

135. An insurer's underpayment of a claim violates Regulation 2695.7, subdivision (g) because it represents an attempt to settle a claim with an unreasonably low settlement offer.

136. PacifiCare knowingly committed these acts in violation, as those terms are used in section 790.03, subdivision (h) and as those terms are defined in Regulation 2695.2, subdivision (*l*).

137. The thousands of violations for this category represent a frequency that indicates a general business practice, as those terms are used in section 790.03, subdivision (h).

138. PacifiCare's failures to correctly pay claims were willful, as that term is used in section 790.035, subdivision (a) and as that term is defined in Regulation 2695.2, subdivision (y).

139. PacifiCare's failures to correctly pay claims do not constitute the inadvertent issuance, amendment, or servicing of a policy or endorsement, as those terms are used in section 790.035, subdivision (a).

140. PacifiCare committed 3,700 acts in violation of section 790.03, subdivisions (h)(1), (h)(3), and (h)(5) and Regulation 2695.7, subd. (g).

H. Failure to Acknowledge the Receipt of Claims

141. Section 10133.66, subdivision (c) requires that insurers identify and acknowledge claims, and that insurers disclose the recorded date of receipt of the claims in the same manner as the claim was submitted or provided.

142. For claims submitted by paper, section 10133.66, subdivision (c) requires that insurers identify and acknowledge those claims, and that insurers disclose the recorded date of receipt of the claims, by letter, unless the insurer and the provider mutually agree to another accessible method.

143. Each of the claims that were submitted by paper and not acknowledged by paper represents an act in violation of section 790.03, subdivision (h)(2), which requires insurers to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies. For purposes of provider claims, the 30 working-days deadline of section 10123.13, subdivision (c) defines what constitutes reasonable promptness under section 790.03, subdivision (h)(2).

144. PacifiCare's failure to acknowledge the receipt of claims constitutes acts in violation of section 790.03, subdivision (h)(3) because not sending letters acknowledging the receipt of claims reflects a failure to adopt and implement reasonable standards for prompt investigation and processing of claims arising under insurance policies. (Exh. 1184, p. 119:25-28.)

145. PacifiCare's failure to acknowledge the receipt of claims constitutes acts in violation of section 10133.66, subdivision (c), which requires insurers to acknowledge the receipt of claims in the same manner as the claim is submitted or provided.

146. PacifiCare's failure to acknowledge the receipt of claims constitutes acts in violation of Regulation 2695.5, subdivision (e), which requires insurers to acknowledge the receipt of claims.

147. PacifiCare's maintaining of a website did not constitute compliance with any of these laws.

148. PacifiCare's maintaining of a telephone number did not constitute compliance with any of these laws.

149. PacifiCare knowingly committed these acts in violation, as those terms are used in section 790.03, subdivision (h) and as those terms are defined in Regulation 2695.2, subdivision (*l*).

150. The number of acts committed in violation of section 790.03, numbering in the tens of thousands, is sufficiently large to indicate a general business practice not to acknowledge paper claims. In addition, to the extent that the violations were caused by a parameter set in the claims platform, that is further evidence of a general business practice, since by definition the logic given to the platform defines the company's invariable practice for claims sent to that platform and subject to the parameter. (Exh. 1184, p. 126:18-22.)

151. CDI has not sought a finding of willfulness for these acts in violation. They will be treated as non-willful acts in violation.

152. PacifiCare's failure to send acknowledgment letters were not the inadvertent issuance, amendment, or servicing of a policy or endorsement, as those terms are used in section 790.035, subdivision (a). There was no issuance or amendment. Failure to acknowledge a claim represents a failure to service, not the servicing, of a policy. (Exh. 1184, p. 126:23-127:2.)

153. PacifiCare committed 56,463 acts in violation of section 790.03, subdivisions (h)(2) and (h)(3), section 10133.66, subdivision (c), and Regulation 2695.5, subdivision (e).

I. Failure to Timely Respond to Provider Disputes

154. Section 10123.137, subdivision (a) requires insurers to establish a "fast, fair, and cost-effective dispute resolution mechanism" and subdivision (c) of that section requires insurers to "resolve each provider dispute consistent with applicable law and issue a written determination within 45 working days" of receipt of the dispute.

155. Section 790.03, subdivision (h)(2) requires insurers to act reasonably promptly upon communications with respect to claims. For purposes of provider disputes, the 45

working-days deadline of section 10123.137, subdivision (c) defines what constitutes reasonable promptness under section 790.03, subdivision (h)(2).

156. A written communication from a provider disputing the adjudication of a claim is a communication with respect to a claim within the meaning of section 790.03, subdivision (h)(2). PacifiCare's failure to respond to these communications within 45 working days constitutes acts in violation of section 790.03, subdivision (h)(2).

157. PacifiCare's failure to timely respond to provider disputes constitutes acts in violation of section 790.03, subdivision (h)(3) because not investigating and resolving disputed claims reflects a failure to adopt and implement reasonable standards for prompt investigation and processing of claims arising under insurance policies.

158. PacifiCare knowingly committed these acts in violation, as those terms are used in section 790.03, subdivision (h) and as those terms are defined in Regulation 2695.2, subdivision (*l*).

159. PacifiCare's failure to timely respond to provider disputes does not constitute an inadvertent issuance, amendment, or servicing of a policy or endorsement, as those terms are used in section 790.035, subdivision (a).

160. PacifiCare's failure to timely respond to provider disputes was willful, as that term is used in section 790.035, subdivision (a) and as that term is defined in Regulation 2695.2, subdivision (y).

161. PacifiCare committed 1,510 acts in violation of section 790.03, subdivision (h)(2) and (h)(3) and section 10123.137, subdivision (c).

J. Illegally Closing or Denying Claims When Requesting Additional Information

162. PacifiCare's practice of closing or denying a claim when it is needs additional information violates sections 10123.13, subdivision (a) and 10123.147, subdivision (a), which require that claimants be notified within 30 working days if a claim is being contested or denied.

163. Though PacifiCare was contesting these claims, it wrongly notified claimants that the claims were being closed or denied. (Exh. 1184, p. 138:4-7.)

164. Closing or denying a claim when requesting additional information constitutes an act in violation of section 790.03, subdivision (h)(1). Informing a claimant that a claim has been closed or denied, when it is in fact being contested, is a misrepresentation of a pertinent fact relating to coverages. (Exh. 1184, p. 137:27-138:2.)

165. PacifiCare violated section 790.03, subdivision (h)(3), which prohibits failing to adopt and implement reasonable standards for the prompt investigation and processing of claims. (Exh. 1184, p. 138:2-4.) PacifiCare has adopted and implemented a standard for the prompt investigation and processing of claims that is unreasonable. By closing or denying a claim that needs further investigation, PacifiCare unreasonably delayed the investigation and processing of the claim. (E.g., Exh. 40, p. 4014 [claim received December 12, 2005, denied and closed on December 13, 2005, not paid until March 8, 2007]; Exh. 41, pp. 9454-9455 [claim received April 4, 2006, denied and closed on April 12, 2006, not paid until March 20, 2007].)

166. PacifiCare's practice violates Regulation 2695.7, subdivision (d) because by closing or denying the claim, instead of leaving it open while the company awaits further information, is failing to "conduct and diligently pursue a thorough, fair and objective investigation." (Exh. 1184, p. 138:7-10.)

167. PacifiCare knowingly committed these acts in violation, as those terms are used in section 790.03, subdivision (h) and as those terms are defined in Regulation 2695.2, subdivision (*l*).

168. PacifiCare had a general business practice of closing or denying claims when it was requesting additional information. (Exh. 1184, p. 140:10-12.)

169. CDI has not sought a finding of willfulness for these violations. They will be treated as non-willful acts in violation.

170. PacifiCare's violations for closing or denying claims do not constitute the inadvertent issuance, amendment, or servicing of a policy or endorsement, as those terms are used in section 790.035, subdivision (a).

171. PacifiCare committed at least 57 acts in violation of these sections by closing or denying claims when requesting additional information.

172. PacifiCare's illegal practice of closing or denying claims when requesting additional information constitutes one act in violation of these sections.

K. Sending Untimely Collection Notices on Overpaid Claims

173. Section 10133.66, subdivision (b) requires that insurers make any request for reimbursement in writing within 365 days of the date that the allegedly overpaid claim was paid by the insurer.

174. Section 10133.66, subdivision (b) requires that such a written request for reimbursement must clearly identify: (i) the claim; (ii) the patient name; (iii) the date of service; and (iv) a clear explanation of the basis upon which it is believed that claim was overpaid.

175. A request for reimbursement by an insurer that does not comply with each of these requirements is illegal.

176. Making demands for reimbursement that are untimely violates section 790.03, subdivision (h)(1) because the insurer is incorrectly representing to the claimant that it has the right to collect those additional amounts. That is a misrepresentation of a pertinent fact because an insurer does not have the right to recover such overpayments if it fails to request reimbursement in writing within 365 days of payment of the claim, or if its written notice fails to clearly identify any of the items of information list in section 10133.66, subdivision (b). (Exh. 1184, p. 143:1-4.)

177. Sending untimely reimbursement demand letters reflects a failure to adopt and implement reasonable standards for the prompt investigation and processing of claims, in violation of section 790.03, subdivision (h)(3). (Exh. 1184, p. 143:4-7.) By demanding that claimants reimburse a previously paid claim, the insurer is effectively re-opening that claim

and imposing on the claimant the burdens of verifying that the claim was indeed overpaid and, if so, sending reimbursement back to the insurer. If that demand is untimely, and the insurer does not in fact have the right to seek reimbursement, then the insurer has not promptly investigated the claim and is wrongfully delaying the complete processing of the claim.

178. PacifiCare has taken the position that claims that are *paid* before January 1, 2006, are not subject to the statute. (Exh. 5392, p. 1645; RT 12715:16-19 (Bugiel).)

179. PacifiCare is wrong. The date of payment of the claim does not limit the statute's applicability. Rather, the statute makes the sending of reimbursement requests more than 365 days after date of payment the violative act.

180. Sending untimely requests for reimbursements after the statute became effective, on January 1, 2006, is prohibited, regardless of when the claims were originally paid.

181. PacifiCare knowingly committed these acts in violation, as those terms are used in section 790.03, subdivision (h) and as those terms are defined in Regulation 2695.2, subdivision (*l*).

182. The thousands of violations for this category represent a frequency that indicates a general business practice, as those terms are used in section 790.03, subdivision (h). (Exh. 1184, p. 152:23-24.)

183. PacifiCare's violations for sending untimely overpayment letters were willful, as that term is used in section 790.035, subdivision (a) and as that term is defined in Regulation 2695.2, subdivision (y).

184. PacifiCare's violations for sending untimely overpayment letters do not constitute the inadvertent issuance, amendment, or servicing of a policy or endorsement, as those terms are used in section 790.035, subdivision (a).

185. PacifiCare committed 1,934 acts in violation of section 10133.66, subdivision (c) and section 790.03, subdivisions (h)(1) and (h)(3).

L. Failure to Maintain Complete Claim Files

186. Regulation 2695.3, subdivision (a) makes every licensee's claim files subject to examination by the Commissioner and requires that those files contain "all documents, notes and work papers (including copies of all correspondence) which reasonably pertain to each claim in such detail that the pertinent events and the dates of the events can be reconstructed and the licensee's actions pertaining to the claim can be determined."

187. Subdivision (b) specifies three additional requirements for insurers — that they:

> "(1) maintain claim data that are accessible, legible and retrievable for examination so that an insurer shall be able to provide the claim number, line of coverage, date of loss and date of payment of the claim, date of acceptance, 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
>
> "(2) record in the file the date the licensee received, date(s) the licensee processed and date the licensee transmitted or mailed every material and relevant document in the file; and
>
> "(3) maintain hard copy files or maintain claim files that are accessible, legible and capable of duplication to hard copy; files shall be maintained for the current year and the preceding four years."

188. An insurer that fails to maintain in its claim files all documents pertaining to claims and claim data for the claim number, line of coverage, and relevant dates violates this Regulation.

189. An insurer that is unable to produce claim data within a reasonable time has failed to maintain claim data that are accessible, legible and retrievable for examination, in violation of Regulation 2695.3, subdivision (b).

190. Failing to produce claim data for two years is unreasonable and constitutes a violation of Regulation 2695.3, subdivision (b).

191. Failures to maintain a complete claim file, if committed knowingly or with such frequency as to indicate a general business practice, also violate section 790.03, subdivision (h)(3), if those failures affect the prompt investigation and processing of claims. (Exh. 1184, p. 153:17-20.)

192. Failures to maintain a complete claim file violates section 790.03, subdivision (h)(2), if the failures prevents the insurer from acknowledging and acting reasonably promptly upon communications with respect to claims." (Exh. 1184, p. 153:20-22.)

193. PacifiCare knowingly committed these acts in violation, as those terms are used in section 790.03, subdivision (h) and as those terms are defined in Regulation 2695.2, subdivision (*l*).

a. PacifiCare is charged with knowledge of the documents it maintains in its own claim files. (Exh. 1184, p. 155:3-6.)

194. CDI has not sought a finding of willfulness for these violations. They will be treated as non-willful acts in violation.

195. PacifiCare's failures maintain complete claim files here do not constitute an inadvertent issuance, amendment, or servicing of a policy. (Exh. 1184, p. 155:10-13.)

196. PacifiCare committed 15 acts in violation of section 790.03, subdivision (h)(2) and Regulation 2695.5, subdivision (a).

M. Failure to Timely Respond to CDI Inquiries

197. Section 790.03, subdivision (h)(2) requires that insurers acknowledge and act reasonably promptly upon any communications with respect to claims.

198. Regulation 2695.5, subdivision (a) defines what "reasonably promptly" meant for purposes of insurers responding to CDI inquiries: They are required to provide a complete written response addressing all the issues raised by CDI and including copies of all documentation and claim files requested by CDI within 21 calendar days.

199. PacifiCare knowingly committed these acts in violation, as those terms are used in section 790.03, subdivision (h) and as those terms are defined in Regulation 2695.2, subdivision (*l*). (Exh. 1184, p. 160:6-7.)

200. CDI has not sought a finding of willfulness for PacifiCare's failures to timely respond to CDI. They will be treated as non-willful acts in violation.

201. PacifiCare's failures to timely respond to CDI do not constitute the inadvertent issuance, amendment, or servicing of a policy or endorsement, as those terms are used in section 790.035, subdivision (a).

202. PacifiCare committed 29 acts in violation of section 790.03, subdivision (h)(2) and Regulation 2695.5, subdivision (a).

N. Failure to Train Claims Agents on the Fair Claims Settlement Practices Regulations

203. Section 790.03, subdivision (h)(2) requires that insurers adopt and implement reasonable standards for the prompt investigation and processing of claims.

204. Regulation 2695.6 further defines that provision to require that insurers provide "thorough and adequate training regarding the regulations to all their claims agents." (Reg. § 2695.6, subd. (b).)

205. The Regulations define "claims agent" as: "any person employed or authorized by an insurer, to conduct an investigation of a claim on behalf of an insurer or a person who is licensed by the Commissioner to conduct investigations of claims on behalf of an insurer. The term 'claims agent,' however, shall not include the following: (1) an attorney retained by an insurer to defend a claim brought against an insured; or, (2) persons hired by an insurer solely to provide valuation as to the subject matter of a claim." (Reg. 2695.2, subd. (d).)

206. Failing to provide such training on the Regulations to any claims agent therefore violates section 790.03, subdivision (h)(2) and Regulation 2695.6, subdivision (b). (See Exh. 1184, p. 162:3-8.)

207. Each of the 14 appeals processors in PacifiCare's Appeals & Grievances department qualifies as a claims agent under the Regulations, and must be provided training on the Regulations.

208. Each of the nine claims agents in J&R's appeals department qualifies as a claims agent under the Regulations, and must be provided training on the Regulations.

209. PacifiCare knowingly committed these acts in violation, as those terms are used in section 790.03, subdivision (h) and as those terms are defined in Regulation 2695.2, subdivision (*l*).

210. CDI has not sought a finding of willfulness for these violations. Accordingly, they will be treated as non-willful acts in violation.

211. PacifiCare's failures to train claims agents do not constitute the inadvertent issuance, amendment, or servicing of a policy or endorsement, as those terms are used in section 790.035, subdivision (a).

212. PacifiCare committed 23 acts in violation of section 790.03, subdivision (h)(2) and Regulation 2695.6, subdivision (b).

O. Misrepresentations to CDI

213. PacifiCare made a number of misrepresentations to CDI during the 2007 MCE. CDI is not seeking legal conclusions with respect to those misrepresentations, but is requesting that they be considered as aggravating circumstances in other violation categories.

P. Failure to Conduct Business in Company's Own Name

214. Section 880 requires that "every insurer shall conduct its business in this State in its own name."

215. This requires that insurers identify the legal name of the underwriting company on all correspondence to members and providers, such as claim-related letters and EOBs and EOPs.

216. Each failure to do so constitutes a separate act in violation of section 880.

217. Each failure to include an insurer's legal name on correspondence also constitutes an act in violation of section 790.03, subdivision (h)(1).

b. The legal name of an insurer is a pertinent fact.

c. Failing to include the legal name of an insurer on correspondence to members and providers constitutes a misrepresentation of a pertinent fact.

218. PacifiCare knowingly committed these acts in violation, as those terms are used in section 790.03, subdivision (h) and as those terms are defined in Regulation 2695.2, subdivision (*l*).

219. CDI has not sought to charge these violations as willful acts. They will be treated as non-willful acts in violation.

220. PacifiCare's failures to include its legal name on correspondence do not constitute the inadvertent issuance, amendment, or servicing of a policy or endorsement, as those terms are used in section 790.035, subdivision (a).

221. PacifiCare committed 29 acts in violation of section 790.03, subdivision (h)(2) and Regulation 2695.5, subdivision (a) for failing to conduct business in its own name.

Q. Failure to Timely Respond to Claimants

222. Section 790.03, subdivision (h)(2) requires that insurers acknowledge and act reasonably promptly upon any communications with respect to claims.

223. Regulation 2695.5, subdivision (b) defines what "reasonably promptly" means in the context of responding to communications with claimants: They are required to provide a complete response "immediately, but in no event more than fifteen (15) calendar days after receipt of that communication."

224. An insurer that fails to respond to such a communication from a claimant within 15 days, or fails to provide a complete response to a claimant violates these provisions. (Exh. 1184, p. 167:7-14.)

225. PacifiCare knowingly committed these acts in violation, as those terms are used in section 790.03, subdivision (h) and as those terms are defined in Regulation 2695.2, subdivision (*l*).

226. CDI has not sought a finding of willfulness for PacifiCare's failures to timely respond to claimants. They will be treated as non-willful acts in violation.

227. PacifiCare's failures to timely respond to claimants do not constitute the inadvertent issuance, amendment, or servicing of a policy or endorsement, as those terms are used in section 790.035, subdivision (a).

228. PacifiCare committed nine acts in violation of section 790.03, subdivision (h)(2) and Regulation 2695.5, subdivision (a) by failing to timely respond to communications from claimants.

R. Failure to Implement a Policy Regarding Recording the Date of Receipt of Claims

229. Section 790.03, subdivision (h)(3) requires having in place a policy for claims examiners about recording the correct date that claims are received by an insurer.

230. Regulation 2695.3, subdivision (b) requires insurers to maintain in the claim file information regarding the date the licensee received any claims or claim-related documents.

231. Regulation 2695.3, subdivision (a) requires insurers to maintain in claim files information in such detail that the dates of the events can be reconstructed and the licensee's actions pertaining to the claim can be determined.

232. The failure to have in place a policy instructing claims examiners to record the proper date of receipt of a claim violates these provisions.

233. Each instance in which an examiner fails to properly record the date of receipt further constitutes an act in violation of these provisions.

234. PacifiCare knowingly committed these acts in violation, as those terms are used in section 790.03, subdivision (h) and as those terms are defined in Regulation 2695.2, subdivision (*l*).

235. CDI has not sought to charge these violations as willful acts in violation. They will be treated as non-willful acts in violation.

236. PacifiCare's failure to adopt and implement a policy on recording claim received dates does not constitute the inadvertent issuance, amendment, or servicing of a policy or endorsement, as those terms are used in section 790.035, subdivision (a).

237. PacifiCare committed two acts in violation of section 790.03, subdivision (h)(3) and Regulation 2695.3, subdivisions (a) and (b).

S. Failure to Conduct a Thorough Investigation

238. Section 790.03, subdivision (h)(3) requires that insurers adopt and implement reasonable standards for the prompt investigation and processing of claims.

239. Section 790.03, subdivision (h)(5) requires that insurers attempt in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

240. Regulation 2695.7, subdivision (d) specifies the obligations of section 790.03, subdivisions (h)(3) and (h)(5) by requiring that "[e]very insurer shall conduct and diligently pursue a thorough, fair and objective investigation and shall not persist in seeking information not reasonably required for or material to the resolution of a claim dispute."

241. An insurer that fails to conduct a thorough investigation into a claim violates section 790.03, subdivisions (h)(3) and (h)(5) and Regulation 2695.7, subdivision (d).

242. An insurer that fails to conduct a thorough investigation of a claim may as a consequence illegally represent pertinent facts or insurance policy provisions in violation of section 790.03, subdivision (h)(1)

243. An insurer that fails to conduct a thorough investigation of a claim may as a consequence fail to affirm or deny claims within a reasonable time in violation of section 790.03, subdivision (h)(4).

244. PacifiCare knowingly committed these acts in violation, as those terms are used in section 790.03, subdivision (h) and as those terms are defined in Regulation 2695.2, subdivision (*l*).

245. CDI has not sought a finding of willfulness for these violations. They will be treated as non-willful acts in violation.

246. PacifiCare's failures to conduct a thorough investigation do not constitute the inadvertent issuance, amendment, or servicing of a policy or endorsement, as those terms are used in section 790.035, subdivision (a).

247. PacifiCare committed 52 acts in violation of section 790.03, subdivisions (h)(1), (h)(3), (h)(4), and (h)(5) and Regulation 2695.7, subdivision (b) for

failing to conduct a thorough investigation. Of those 52 acts in violation, 46 are being charged in this category.

T. Misrepresentations of Pertinent Facts

248. Section 790.03, subdivision (h)(1) prohibits insurers from "[m]isrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages at issue."

249. Regulation 2695.4, subdivision (a) adds to that prohibition by imposing an affirmative obligation on insurers to disclose "all benefits, coverage, time limits or other provisions of any insurance policy issued by that insurer that may apply to the claim presented by the claimant."

250. Regulation 2695.4, subdivision (a) requires that insurers disclose to claimants whenever there is a reasonable possibility that additional benefits under a policy might be owed and to cooperate with claimants in determining the additional amounts owed.

251. An insurer that provides to claimants incorrect information relating to a claim violates section 790.03, subdivision (h)(1) and Regulation 2695.4, subdivision (a).

252. PacifiCare knowingly committed these acts in violation, as those terms are used in section 790.03, subdivision (h) and as those terms are defined in Regulation 2695.2, subdivision (*l*).

253. CDI has not sought a finding of willfulness for these violations. They will be treated as non-willful acts in violation.

254. PacifiCare's misrepresentations of pertinent facts do not constitute the inadvertent issuance, amendment, or servicing of a policy or endorsement, as those terms are used in section 790.035, subdivision (a).

255. PacifiCare committed 85 acts in violation of section 790.03, subdivision (h)(1) and Regulation 2695.4, subdivision (a) by making misrepresentations to claimants regarding coverages.

V. AGGREGATE PENALTY

256. No legal conclusions are being sought here relating to this section of CDI's Opening Brief.

VI. CONCLUSION

257. No legal conclusions are being sought here relating to this section of CDI's Opening Brief.

Date: May 31, 2012

Respectfully submitted,

STRUMWASSER & WOOCHER LLP

CALIFORNIA DEPARTMENT OF INSURANCE LEGAL DIVISION

By:_____
Bryce A. Gee

Attorneys for the California Department of Insurance

PROPOSED ORDER

Based on the foregoing, IT IS ORDERED that:

1. The Department's allegations against PacifiCare, contained in the First Amended Order to Show Cause; Statement of Charges/Accusation; Notice of Monetary Penalty, of violations of Insurance Code sections 790.03, 10123.13, 10123.137, 10123.147, 10133.66, 10169, 10198.7, 10708, and the Fair Claims Settlement Practices Regulations, California Code of Regulations, title 10, chapter 5, subchapter 7.5, as more fully described in the Findings of Fact and Legal Conclusion in this Decision, are sustained.

2. PacifiCare shall pay a monetary penalty to the State of three hundred twenty-five million dollars ($325,000,000), within ten days after the adoption of this decision by the Commissioner.

This proposed decision is submitted on the basis of the entire record in this proceeding and I recommend its adoption as the decision of the Insurance Commissioner of the State of California.

DATED: _____

_____
RUTH ASTLE
Administrative Law Judge