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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

**PRE-FILED DIRECT TESTIMONY OF
RONALD BOEVING**

Judge: Hon. Ruth Astle

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

1 I. Introduction

2 Q. Please state your name.

3 A. Ronald Boeving.

4 Q. What is your business address?

5 A. 518 Rivershire Place, Lincolnshire, Illinois 60069.

6 Q. By whom are you employed?

7 A. I am self-employed, providing consulting services through my business, Boeving
8 Associates — Strategic IT Management Consulting.

9
10 II. Qualifications

11 Q. What is your occupation?

12 A. I am a consultant to a wide variety of companies in the healthcare field. Boeving
13 Associates specializes in Information Technology (IT) management and planning for IT support
14 of critical initiatives for healthcare companies. Among other things, I provide these companies
15 advice on planning and preparing for the integration of IT components, which includes
16 identifying the risks that the IT components present and quantifying the time and cost necessary
17 to address those risks.

18 Q. Is Exhibit _____ (Boeving A) a copy of your Curriculum Vitae that
19 accurately reflects your professional experience and educational background?

20 A. Yes.

21 Q. In the course of your career, have you had experience with the integration of
22 health insurance companies?

23 A. Yes. For example, at First Health I led the IT integration for about 15
24 acquisitions, about 5 relatively large acquisitions (above \$150 million) and about 10 smaller
25 companies. I led the full integration of a variety of PPO repricing systems and group-health
26 claims processing systems in support of the First Health PPO business. I led the conversion and
27 integration of three custom claims administration systems: ACTII (original First Health), the
28 "Miners system," and CAS (the system that was running the claims processing for CNA's

1 offshoot business, acquired in 2003). Each of these claims systems and the business they served
2 was integrated to run on First Health's standard custom system called "First Claim."
3

4 **III. Purpose of Testimony**

5 **Q. What is the purpose of your testimony?**

6 A. I have been asked by the California Department of Insurance (CDI or the
7 Department) to evaluate certain evidence and to offer my opinion regarding management and
8 execution of aspects of the operation of PacifiCare Life and Health Insurance Company (PLHIC
9 or PacifiCare) following its acquisition by UnitedHealth Group, Inc. (UHG or United). In
10 particular, I have been asked to review evidence regarding the planning and execution of the
11 migration and integration of certain functions of PLHIC into the facilities and organizations of
12 other UHG subsidiaries following UHG's acquisition of PLHIC and its affiliates in
13 December 2005.
14

15 **IV. Materials Reviewed**

16 **Q. Have you formed an opinion regarding the subject of your testimony?**

17 A. Yes, I have.

18 **Q. Did you review any materials to form the basis of your opinion?**

19 A. Yes, I did.

20 **Q. What materials did you review?**

21 A. I have reviewed exhibits in evidence in this matter, including emails, project plans
22 and presentations, and the like. I was present for parts of the testimony of Scott Burghoff and
23 Ross Lippincott. In addition, I have reviewed the transcripts of the testimony of Susan Berkel,
24 Scott Burghoff, A.J. Labuhn, Ross Lippincott, Elena McFann, Dirk McMahon, Nancy Monk,
25 Jonathon Murray, Martin Sing, Samia Soliman, Kelly Vavra, Ellen Vonderhaar, Ruth Watson,
26 Divina Way, and David Wichmann. Exhibit _____ (Boeving B) contains a list of the exhibits
27 in evidence I have reviewed.
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V. Summary of Findings

Q. Please summarize your principal findings.

A. In general, the materials I have reviewed indicate that the United approach to integration of PacificCare's IT functions underestimated the complexity and difficulties involved, directly driving up the error rates. Since there were not sufficient effective mechanisms to properly monitor, communicate, and manage error rates down, problems rapidly escalated until they became emergencies. I have not seen evidence that would lead me to believe that United ever undertook an effective corrective action plan to remedy the overall situation, indicating that top level leadership failed to sound the alarm or even characterize the prevailing error levels as "unacceptable." Instead, they characterized customer complaints in reaction to these errors as "noise," indicating that the fault lay with customers and not with operations, or that there was no problem at all — that the complaints were trivial. The extent of errors leading to the violations CDI has cited was largely avoidable.

**VI. General Observations About IT Integration
in the Health Insurance Industry**

Q. Are there recurring issues that present repeated challenges to the integration of an acquired health insurance company?

A. Yes. In my experience, one of the greatest integration challenges involves the joining of the data sets between acquirer and acquired. Healthcare data supporting insurance operations is complex primarily because of the language in contracts for hospitals and physicians and the fee schedules for services. To inter-relate data sets you need to cross-map every data field and this requires painstaking translation of the complex language in the sets. You need to form a team of the subject matter experts in both entities and properly lead and incent them to a common goal.

In order to be successful at integration, management must be committed to service and operational excellence; must take accountability, on an "end-to-end" basis, for all projects in the integration; must effectively communicate to staff the goals of the integration and the status

1 of integration projects; must effectively and aggressively seek to retain subject matter experts
2 and institutional knowledge from the acquired company; must establish and strictly monitor
3 meaningful metrics to measure the quality of operational processes; must establish escalation
4 processes that ensure that problems are promptly identified and remediated; must actively and
5 effectively manage the conflict between risk and cost.

6 **Q. Did you form a general opinion on how United handled the integration of**
7 **PacifiCare?**

8 A. Yes. United management handled the integration of PacifiCare's business into
9 United's very poorly. I have identified serious flaws in each of the management guidelines listed
10 above:

11 1. While United appeared to have a handful of separate plans for particular aspects
12 of the integration, it lacked an overall plan for the integration that coordinated each of those
13 detached plans. United further failed to adequately plan for the contingency that its integration
14 projects wouldn't materialize as planned. When changes were made to integration projects —
15 for example, the RIMS migration plan — United failed to re-assess previous decisions that were
16 made on the assumption that those integration projects would be executed as planned. In many
17 instances, United's failure to make necessary adjustments to plans and to budgeting left many
18 functions under-resourced and understaffed.

19 2. Many areas lacked end-to-end ownership or accountability for processes that were
20 being transitioned or changed. When problems arose, United employees, including management,
21 engaged in blaming others, instead of seeking to correct those problems. In a related problem,
22 United's culture suffered from deep siloing, as well as poor communications between teams,
23 especially integration teams. The evidence indicates that United's message to its staff was
24 essentially only concern yourself with your particular area and don't offer help to others. This
25 philosophy inhibited cross-team cooperation and undermined the achievement of end-to-end
26 control and monitoring, which in turn prevented effective root cause analysis and problem
27 resolution.

1 3. United failed to implement adequate controls to monitor and detect integration
2 problems. For instance, in many of the integration projects, reconciliation or other error-
3 detection reports were completely lacking, poorly designed, or not adequately monitored. This
4 resulted in problems persisting for long periods without United detecting them.

5 4. The lack of adequate controls to detect and analyze problems led to a failure to
6 correctly identify true root causes of integration problems. United implemented band-aid fixes
7 rather than effective corrective actions that addressed the underlying problems. This in turn
8 resulted in a chronic recurrence of problems, which could have been avoided had the root cause
9 been properly addressed at the outset.

10 5. United management failed to take adequate measures to retain PacifiCare subject
11 matter experts or to preserve PacifiCare institutional knowledge necessary for a smooth
12 integration. United failed to effectively utilize and empower the legacy staff that it did retain. In
13 implementing process changes, United failed to sufficiently listen to and heed constructive
14 warnings and advice from legacy PacifiCare staff.

15 6. There was a serious lack of focus on, or even interest in, customers' needs during
16 the integration. United management was clearly concerned with quickly establishing
17 efficiencies, that is to say, cost-savings and synergies, in PacifiCare's processes, but I have seen
18 no evidence of a comparable commitment to maintaining customer service levels.

19 7. United management failed to adequately assess and manage the risks it was taking
20 in the integration projects. There are, of course, risks any time a company plans to make
21 significant changes to processes, but the evidence I have seen reflects that United failed to
22 properly analyze and minimize those risks. Economies are a critical success factor in integration,
23 but they must not be achieved at the cost of taking on unacceptable levels of risk.

24 8. United failed to adequately budget for existing PacifiCare systems and processes,
25 in particular PacifiCare's PPO claim engine, RIMS, which had not been upgraded or adequately
26 maintained since the acquisition. When plans and strategies changed, United further failed to
27 adjust its budgets to account for those changes.

28

1 Nor was there any person or committee that had overall responsibility for the
2 integration or for the multiple integration teams. (E.g., Exhibit 448, p. 8700.) As PacifiCare’s
3 counsel stated on the record and as confirmed by Mr. Burghoff, a United VP of Integration and
4 Business Alignment, there was no single person who could be identified as the person most
5 knowledgeable about the integration. United’s Senior Advisory Panel, made up of officers and
6 other executive sponsors, had the makings of a body that could have actively overseen and
7 coordinated the overall integration effort. But there is no evidence that, in practice, it served as
8 anything more than a passive, hands-off team that never took responsibility for managing the
9 integration or for addressing and remediating problems with the integration. Instead, control was
10 delegated to the three integration teams described above that operated independently and with
11 minimal cross-communication or coordination.

12 Nor did I see any evidence that the integration teams picked up responsibility for
13 managing their projects end-to-end. Mr. Burghoff’s role appeared to be limited to tracking and
14 reporting the progress of the integration projects within his team. Mr. Greenberg also did not
15 manage projects or drive target dates. Mr. Labuhn similarly took a passive role in overseeing
16 projects purportedly within his responsibility. Reflecting upon the work of his integration team
17 to “drive down operating costs,” he explained that there “were certain circumstances where
18 functional areas were understaffed/underbudgeted. However, we could not transition
19 budget/headcount that we did not have.” (Exhibit 546.) Thus, instead of taking ownership and
20 attempting to obtain appropriate staffing and budgeting, Mr. Labuhn was content to allow those
21 functional areas to be understaffed and underbudgeted. His role, in his mind, was simply “the
22 mechanics of the numbers related to the budget rules of the road for transitioning FTEs we had
23 been instructed to follow.” (Reporter’s Transcript (RT) 5537:1-5.²) “Uniprise is indifferent as to
24 whether the headcount/budget is adequate. Simply, it was what was available to send,” Mr.
25 Labuhn said. (Exhibit 543, p. 4755.) The lack of taking responsibility to take appropriate
26 corrective action when surprises occurred and when plans changed allowed problems to grow

27 _____
28 ²The numbers following the RT citations refer to “Page number: line number” of the
Reporter’s Transcript.

1 and fester. A critical factor of success in integrations is that you quickly identify and resolve any
2 problems that may occur.

3 The lack of an overall plan or leadership resulted in the integration teams focusing
4 only on their particular projects, even when those projects conflicted with the goals of other
5 integration activities. As Ms. Berkel recommended in a “lessons learned” presentation in
6 January 2007, “[l]arge integration projects need to have a single reporting mechanism to
7 eliminate siloed approach and conflicting priorities”; she further counseled that they should
8 “[c]reate [a] single oversight committee, eliminate multiple sub-committees.” (Exhibit 644,
9 p. 5643.) It was not until April 2007, almost a year and a half after the acquisition closed, that a
10 plan was proposed to integrate the integration teams, so to speak, into a single governance
11 structure and approach to address the “inconsistent communication, [and] collaboration” of the
12 then-existing structure. (Exhibit 801.)

13 Top level management, like David Wichmann, Executive VP and CFO of
14 UnitedHealth Group and President of UnitedHealth Group Operations and Technology, and Dirk
15 McMahon, the COO of UnitedHealthcare, largely took a hands-off approach to managing and
16 overseeing the integration. Even in a company as large as United, I would expect to see
17 executives like Messrs. Wichmann and McMahon more involved in the significant aspects of the
18 integration, and to take or direct corrective actions, especially as serious problems arose. But
19 they weren’t, opting to rely heavily on their subordinates to identify issues and resolve them,
20 without much supervision.

21 For example, Mr. McMahon testified that he had no idea how the multiple
22 integration teams interacted, how the PacifiCare integration was budgeted, or even who approved
23 the decision to reverse course on RIMS migration — significant aspects of the integration that
24 management should be aware of and involved in. In fact, Mr. McMahon was unaware of many
25 of the significant problems with the PacifiCare integration as they were occurring, and only
26 learned of them after-the-fact in July 2007 when he reviewed Ms. Berkel’s Input to Board
27 Presentation (Exhibit 5265). And Mr. McMahon testified that, upon learning of the problems
28 reflected in Ms. Berkel’s memo, he did not require any corrective actions be taken, nor did he

1 seek to determine what persons or teams were responsible for the problems described in that
2 memo. Likewise, even though Mr. Wichmann was dissatisfied with some of the results of the
3 integration, that dissatisfaction did not cause him to become more involved or to demand any
4 specific corrective actions.

5 Both Messrs. Wichmann and McMahon testified that their practice was not to
6 assign fault or blame for problems that occur. As Mr. Wichmann explained, “[i]f you attack
7 people, you end up exacerbating problems. So I wouldn’t go around trying to find out who was
8 to blame for what.” (RT 10633:5-8.) But this failure to hold persons responsible for problems
9 results in no one taking accountability for those problems and no one initiating corrective
10 actions.

11 In particular, end-to-end ownership and accountability was severely lacking in
12 this integration. One particularly acute example of this failure was with the implementation of
13 the Electronic Provider Data Exchange (EPDE) data bridge, which was used to synchronize
14 provider data in United’s database, Network Database (NDB), with RIMS provider data. The
15 entire process of getting data from NDB to RIMS, known as the end-to-end or E2E process,
16 involved multiple components, which included EPDE itself and the PHS Autoload program,
17 which was a legacy PacifiCare application that received the data into RIMS. This process was
18 vital to ensuring that accurate data — including fee schedule data — were being uploaded into
19 RIMS so that claims could be paid correctly.

20 This end-to-end process was ostensibly owned by Ross Lippincott, a United VP,
21 but when problems with the process arose, like the data corruption in RIMS, he refused to own
22 corrective responsibility. (RT 15195:20-25.) Rather, Mr. Lippincott spent considerable effort
23 campaigning to clear EPDE’s good name, disparaging complaints about EPDE as “lore” —
24 misinformed almost superstitious speculation not worthy of corrective action — even while
25 admitting that there was a problem with the “entire end to end process,” of which he was the
26 owner. (Exhibit 921.) Instead of taking remedial action, he focused much of his energy on
27 pointing the finger at processes outside the EPDE feed, in particular the PHS Autoload program
28 (Exhibit 919), even though he had a very limited understanding of that program. By not owning

1 the problem in total, but instead choosing to lay blame on components, he violates the principle
2 of end-to-end responsibility and control. This component-blaming posture makes it impossible
3 to solve problems on a root cause basis. If you focus only on a single component in a process,
4 you might succeed in resolving a particular issue, but the overall process itself continues to fail.
5 A common frustration experienced by data center managers is when the vendor of hardware
6 maintenance is brought in to fix a downed system and they simply point to the software as the
7 problem.

8 Mr. Lippincott should instead have attempted to accurately identify and *fix* the
9 problems with the end-to-end process. Susan Mimick, a United director of Network Operations
10 and Integration, for instance, tried a number of times to get issues with the end-to-end process
11 addressed and resolved — such as the lack of sufficient documentation for the PacifiCare/RIMS
12 applications, and the lack of effective reconciliation controls — but these efforts were largely
13 unsuccessful because of the focus on protecting the reputation of the EPDE feed and an apparent
14 reluctance to allocate resources to these quality measures. If the problem really was with the
15 PHS Autoload program, United should have tried to get a better understanding of that program,
16 determine what was causing the errors, and fix them. United's, and more specifically Mr.
17 Lippincott's, failure to do that resulted in these problems recurring and persisting.

18 Since the problems with the Autoload program arose during Mr. Lippincott's
19 efforts to construct a data bridge between NDB and RIMS, and since those errors within the
20 Autoload program were the responsibility of his team (RT 15186), his attempt to portray those
21 problems as the result of a flawed legacy application was counterproductive. Further, the
22 Autoload program appears to have worked fine before United attempted to modify it to receive
23 data from the NDB database. (Exhibit 917.)

24 As Ms. Mimick recognized, this end-to-end process suffered from serious lack of
25 effective reconciliation controls, which was a recurring problem with other new processes that
26 United implemented throughout the integration. As a result, problems would persist and go
27 undetected for many months. Further, without effective controls, it is difficult to identify the true
28 root cause of problems in order to implement corrective actions that fully remediate the

1 underlying problems; instead, you are more likely to rely upon band-aid fixes that may
2 temporarily correct the specific issue, but allow the underlying problems to recur.

3 Since United had control over the entire end-to-end process for EPDE — that is to
4 say, United owned all the applications and programs within the end-to-end process — there was
5 no reason it couldn't have created reconciliation or validation reports that would confirm proper
6 mapping of the data between the two systems. But the reconciliation reports that United
7 designed to monitor the end-to-end process failed to do this; they provided neither early
8 warnings of problems nor the ability to diagnose root causes. As Ms. Mimick reported, “the
9 Network folks stated they have determined the RIMS data reconciliation reports are not working
10 — they are not pulling through enough mis-matches.” (Exhibit 977.)

11 Another problem was that United simply failed to work many of the reconciliation
12 reports that it had put in place; so even if those reports were detecting problems that could have
13 been fixed, no one at United would have known. For instance, in August 2007, Ms. Mimick
14 complained that “there is not a solid process on how error reports are worked” (Exhibit 970), and
15 later she reported to her boss, Mr. Lippincott, that, indeed, no one had been working the PM fatal
16 error report for several years (Exhibit 976). That PM fatal error report, once it was finally
17 worked, revealed that RIMS would only accept one new provider per day on an auto-loader basis
18 — a limitation that United had been unaware of, but that was causing data integrity issues.
19 (Exhibit 976.)

20 As a result, many problems with this process were discovered only after external
21 customers complained to the company. Ms. Mimick expressed her frustration at the company's
22 inability to detect these problems: “We cannot continue to rely on the provider community to
23 discover issues for us.”

24 The controls for this complex EPDE process were insufficient at the initial rollout
25 and did not get enhanced to a level that satisfied basic quality needs. One recurring EPDE-
26 related issue that caused problems with provider addresses illustrates many of United's
27 deficiencies in executing complex integration tasks. Many providers would have multiple
28 addresses stored in RIMS, such as a mailing address, a billing address, a physical office address,

1 or a prior address. But when there was a change to a provider's address in NDB that was fed to
2 RIMS via EPDE, the Autoload program was unable to determine which of the multiple addresses
3 in RIMS needed to be updated, so it would default to the first address created in RIMS, which
4 was often outdated. (Exhibit 917.) This error resulted in the company sending a large number of
5 provider checks to outdated addresses.

6 This problem appears to have begun on June 22, 2006, when EPDE was first
7 implemented, but went undetected at United until January 2007. It then took United three more
8 months, until April 2007, to determine the root cause.

9 The issue could have and should have been resolved far earlier or even prevented
10 all together. If, before the EPDE feed was implemented, United conducted a full inventory of
11 the differences between RIMS and NDB data structures and obtained a complete understanding
12 of the Autoload program, this issue would likely have been uncovered and prevented; but that
13 due diligence was not conducted. (Exhibit 759, p. 6084; RT 10990:20-10991:12.)

14 As soon as the EPDE feed went live, there were many warning signs that should
15 have indicated that such a problem existed and caused the company to seek out root causes to
16 remediate it. First, United began receiving complaints from providers, as early as June 2006,
17 that claim payment checks were being sent to previous addresses. (E.g., Exhibit 1021.) In
18 November 2006, a PacifiCare employee noticed that several providers' billing addresses had
19 been erroneously changed by the EPDE feed, and asked whether a report could be generated to
20 determine how many other providers had been affected, but there is no indication United ran
21 such a report. (Exhibit 495.) In January 2007, a report showed that 11,000 records in RIMS had
22 changed billing addresses, a significant volume that Elena McFann, the United VP of Network
23 Strategy and Innovation, complained "just doesn't feel right." (Exhibit 850.) Yet I saw no
24 evidence of any concerted effort to determine the root cause of these problems.

25 As a result, United did not realize that the root cause was a structural disconnect
26 between the systems and the Autoload program until three months later, in April 2007, all the
27 while allowing more data corruption to continue. (Exhibit 917.)
28

1 Several other flaws in the design of the EPDE feed and the Autoload program also
2 went undiscovered and uncorrected for long periods of time. One design error, for example,
3 caused the EPDE feed to erroneously “overwrite” some hospital records and to incorrectly list
4 them as medical groups. This problem, which resulted in participating hospitals being omitted
5 from PacifiCare’s online hospital directory (Exhibit 969), was not corrected until eight months
6 after the EPDE launch. (Exhibit 921.) In another example, if an individual provider’s fee
7 schedule or billing address was changed in NDB, the EPDE feed would trigger unintended
8 changes to the corporate TIN owner (the larger entity under which the provider operated for tax
9 purposes, such as a hospital or medical group) record as well. This issue was not identified until
10 November 2007, almost a year-and-a-half after the EPDE go-live date. (Exhibit 955.)

11 The fact that these logic malfunctions went undetected for many months, in some
12 cases over a year, after EPDE was implemented further indicates that necessary quality control
13 measures like reconciliation reports were either not produced, were poorly designed, or weren’t
14 monitored with sufficient attention.

15 United also failed to implement an adequate issue-resolution process for problems
16 that would inevitably occur during the integration, particularly with respect to EPDE. Successful
17 integration efforts, in my experience, often utilize teams of subject matter experts who are
18 available and ready to quickly respond to problems that arise. United assembled such teams,
19 sometimes referred to as “war rooms,” but they failed to equip them with clear escalation paths
20 and accountability for resolving problems. (Exhibit 979.) The EPDE war room seemed to
21 consist of people who lacked a fundamental understanding of EPDE’s functions, while IT
22 personnel, who would have been crucial to that war room’s successful resolution of issues,
23 refused to participate. (Exhibits 948, 985.) As a result, the war rooms were largely ineffective in
24 fixing problems, allowing those problems to linger for long periods.

25 Further, not taking ownership of issues, and not demanding thorough and timely
26 root-cause analysis into problems, seemed to contaminate the leadership style of business leaders
27 as well. Business leaders did not assert their appropriate role in controlling systems or processes
28 that affected their areas, especially in their interactions with the IT department. In my

1 experience, business leaders are actively involved in the IT functions that are supposed to serve
2 their business. That is not what I observed in the case of United.

3 For instance, the problems with the EPDE feed and that end-to-end process had
4 significant negative impacts on the payment of claims. But Ellen Vonderhaar, the United VP
5 responsible for claims, testified that she never objected to the implementation of this process
6 because it wasn't within her responsibility; she saw it as the responsibility of IT or the provider
7 contract area.

8 Ms. Vonderhaar's claims operation was also impacted by the outsourcing of
9 mailroom functions to Lason and by issues surrounding the REVA and DocDNA processes.
10 Though she complained about "finding issue and issue with Lason" (Exhibit 575), I saw no
11 evidence that she ever questioned, asked for quality assurances, or raised any objections to these
12 transitions. Ms. Vonderhaar also testified that she was the "owner" of the DocDNA/document
13 routing component of Lason's PacifiCare work (RT 6370:11-15), but she does not appear to have
14 demanded the opportunity to sign off on new processes before implementation or to have
15 assumed responsibility for driving corrective actions for those processes.

16 Ms. Vonderhaar also took an uninvolved approach to changes that were made to
17 the processes for the transmission of electronic claims. (E.g., RT 6245:7-10 ["Again, I wasn't
18 involved in the EDI process or contracting".]) Ms. Vonderhaar did not participate in the
19 discussions or planning for the migration from the legacy PacifiCare HIPAA EDI gateway to
20 United's EDI gateway called United Front End (UFE). She considered UFE to be the property
21 and the concern of the IT department. I have seen no evidence indicating that either she or
22 someone from her team reviewed trouble logs or error trends related to this changed process; nor
23 did anyone from her shop take responsibility for approving code being promoted into production
24 or for conducting User Acceptance Testing (UAT) — usually the final phase of testing in which
25 the users perform a "real world" test to validate the operational readiness of a new piece of
26 developed code before it goes into production.

27 In my experience, Ms. Vonderhaar's lack of involvement in these transitions is
28 unusual and unacceptable. In my experience, business leaders ordinarily do not rely on IT to the

1 degree Ms. Vonderhaar did. Business leaders should be the ultimate owners of all the processes
2 that affect their business. Not only did Ms. Vonderhaar effectively abdicate her claims
3 responsibilities for these tasks to IT, she apparently did so without even insisting on any quality
4 assurances from IT.

5 Instead, Ms. Vonderhaar was almost singularly focused on monitoring the claim
6 metric for turnaround time (TAT). She appeared to believe that claims payment performance
7 was satisfactory as long as that metric was being met. (Exhibit 5227.) When presented with
8 significant contrary evidence, Ms. Vonderhaar continued to maintain that PacifiCare claims
9 operation was performing well because it was meeting its TAT goals. A March 2007 survey of
10 California brokers voted PacifiCare/United the insurer with the “least timely and accurate claims
11 payment,” yet Ms. Vonderhaar testified that that “wasn’t something I focused on.” (RT 6973:20-
12 21.) And when questioned about problems with the EPDE implementation, DocDNA delays,
13 UFE transition, and Lason transition — each of which had a negative impact on claims payment
14 performance (Exhibit 605) — Ms. Vonderhaar continued to rely upon PacifiCare’s performance
15 against its TAT metric and to refuse to acknowledge the existence of real problems.

16 I have observed a similarly concerning lack of ownership in the Network
17 Management area. That group was highly dependent upon United systems and databases that
18 uploaded and stored provider information, such as fee schedules and demographics. For
19 instance, United used a program called Emptoris to organize the data from provider contracts,
20 which were then uploaded and stored in NDB, which then was used by the EPDE feed to send
21 the data to RIMS. Ms. McFann, the United VP of Network Strategy and Innovation responsible
22 for provider networks, however, testified that she had no responsibility for any of these
23 applications, and wasn’t even aware if “any one person owned EPDE.” (RT 4937:3.) The fact
24 that Ms. McFann, who admitted to ongoing “frustration” with the “data integrity challenges”
25 attributable to the EPDE feed (RT 5031:1-3), did not know who held end-to-end responsibility
26 for EPDE is troubling. Ms. McFann should have made it her business to find out who was
27 responsible for EPDE so she could demand corrective action from that person or team. Although
28

1 she repeatedly complained about problems with the EPDE process that directly affected her
2 operations, I saw no effort by her to drive any corrective actions.

3 Ms. McFann, like Ms. Vonderhaar, also failed to demand quality metrics from IT,
4 nor did she review error logs or error rates with IT. In one instance, a programming error caused
5 some files that should have been loaded via the EPDE link to fail to transmit to RIMS. Ms.
6 Mimick observed that the error had an impact on claims payment, complained that it would have
7 been detected much earlier if the “daily output volumes” were being monitored (presumably a
8 data reconciliation methodology), and questioned whether the new program had been fully tested
9 before implementation. (Exhibit 503.) Ms. McFann forwarded this communication but
10 apparently did not act on Ms. Mimick’s concerns about monitoring and testing. In fact, Ms.
11 McFann testified that she didn’t even know what “daily output volumes” referred to, and that she
12 was not involved in any testing associated with the launch of new code related to provider data.
13 (RT 5097:7-19.)

14 Ms. McFann was similarly uninvolved and uninformed about the process of
15 provider contract loading; she didn’t even know who was in charge of that process.

16 Based on my experience, business leaders like Ms. Vonderhaar and Ms. McFann
17 should demand that controls be implemented to avoid problems or to detect and fix problems
18 quickly and effectively. In my opinion, Ms. Vonderhaar’s and Ms. McFann’s hands-off
19 approach and apparent lack of interest in systems or processes directly contributed to problems
20 not being discovered and persisting for long periods. The appropriate role of such business
21 leaders was that of business owners of these systems and processes, and also as a customer of the
22 IT units that provided technical support. As customers of IT, they should have demanded that
23 they be informed of and involved with systems development and production and, ultimately, that
24 their approval be obtained as a condition of moving ahead with technical implementations. After
25 all, the business leaders, not IT, are those most knowledgeable about how the systems should
26 support their operations.

27 There was also confusion regarding end-to-end ownership for the claim-
28 processing and mail-routing work outsourced to Lason. Ms. Berkel believed that Kelly Vavra

1 was the “ultimate Lason owner” (RT 9834:17-18), meaning “the highest person in our
2 organization that is responsible for Lason” (RT 9797:8-9) and “the person who actually
3 contracted with Lason, negotiated the price, negotiated the performance guarantees” (RT 9798:1-
4 3). Others in the organization also believed that Ms. Vavra “should be driving the controls and
5 remediation efforts.” (Exhibit 706.) Ms. Vavra, however, testified that she was only the owner
6 of the *relationship* with Lason, in the sense that she could contact a high-level Lason director if
7 problems went awry, but that she did not “own” the contract with Lason; she didn’t even know
8 who did own the contract. (RT 14839:8-20.)

9 United also suffered from poor communications and from segregation — or as
10 United called it, siloing — between integration teams and functional areas. Groups did not
11 adequately communicate information and knowledge about their integration projects; there were
12 multiple teams working inter-related projects, but they didn’t know what the other teams were
13 doing. Indeed, many employees complained about the deep siloing and the poor communication
14 at United. Mr. Burghoff observed: “My sense is that things are happening in silos and not as part
15 of an overall coordinated activity.” (Exhibit 437; see also Exhibit 663 [“The departmental silos
16 seem to be getting deeper, internal departments say ‘that is not my job’”].) These silos were
17 allowed, and even encouraged, to develop by United’s “Don’t touch what is not yours”
18 philosophy. In fact, Ruth Watson, a PacifiCare VP of Membership & Accounting Services,
19 testified that she was admonished by Mr. Labuhn for attempting to assist another group; he told
20 her “If you were drowning, you wouldn’t throw your life preserver to someone else.” (RT
21 17687:1-4.)

22 Another aspect of the integration that I found deficient was United’s failure to
23 plan for contingencies and to adapt to changes to the initial strategies. Though it does not appear
24 that United had an overall integration plan, it had formulated a series of going-in positions and
25 objectives for the integration that “articulate[d], based on very preliminary information from the
26 due diligence portion of the transaction, how [United] envision[ed] the integration to be
27 conducted.” (RT 4430:19-23.) Many of the individual work plans and integration projects were
28 based on these going-in positions and objectives. But during the integration, as certain projects

1 proved more difficult or took longer than expected, United failed to adjust or adapt to changes
2 that needed to be made. United also failed to make adjustments to its initial going-in budgets
3 despite significant variances in the projects and strategy.

4 One example of this failure was with United’s strategy for RIMS. The going-in
5 position was that United would do a complete systems migration — i.e., move the claims that
6 were being processed on RIMS to United’s claims-processing system, UNET. (E.g., RT
7 11956:11-21.) This required a technology build on UNET in order to process PacifiCare claims.
8 United had set a target date to complete this migration and be off of RIMS by June 2007, a very
9 aggressive timeline that was set so United could quickly achieve productivity gains and
10 maximize synergies. Many other integration decisions were premised and dependent upon this
11 schedule to migrate off of RIMS. For instance, because it was planning to sunset RIMS in short
12 order, United wanted to “do just the minimum” to keep the system up and running until the
13 migration could be completed. (Exhibit 462.) United also failed to provide adequate
14 maintenance for RIMS, and decided against upgrading the RIMS system to a more current
15 release. Perhaps this posture was understandable for the short-term, if RIMS was indeed going
16 to be sunset by June 2007. But there is no justification for failing to maintain and upgrade a
17 business-critical system such as RIMS in the long-term.

18 Yet it appears that when it became clear that United was unable to migrate the
19 claims off RIMS by that initial target date, the decisions to “do just the minimum” and to not
20 maintain or upgrade were never revisited. In fact, by Fall 2006, a decision had apparently been
21 made that United would scrap its migration plans for RIMS altogether, and instead attempt to
22 move the business from PacifiCare to United paper, meaning that PacifiCare claims would
23 continue to be processed on RIMS for many more years. (Exhibit 5399.) Not only were
24 United’s cost-cutting strategies for RIMS never reassessed, this new plan for RIMS appears not
25 even to have been communicated to many of the other integration teams. As will be discussed
26 more fully below, many of the claims payment issues PacifiCare faced were likely attributable to
27 United’s failure to maintain and upgrade RIMS.

1 The lack of an overall plan and the lack of an overall owner of the integration
2 contributed to United's failures with the RIMS migration. A significant change such as this
3 should have caused someone or some group to reassess the overall plan and how each of the
4 specific integration projects fit into such a plan to determine if certain actions should be changed,
5 but that didn't appear to happen. As Mr. Labuhn complained, after the fact: "Certain actions
6 that were taken by the larger corporate organization were predicated on a migration timeline that
7 has not materialized. Obviously, had we known current migration strategies then, we would
8 have ALL been in a better position to develop a longer-term strategy." (Exhibit 546.)

9 All these shortcomings, independently and collectively, significantly impaired the
10 integration project and confused direction and accountability.

11 **B. Failure to Retain PacifiCare Subject Matter Experts and Institutional Knowledge**

12 **Q. Do you have specific concerns about United's efforts to retain PacifiCare**
13 **subject matter experts and institutional knowledge throughout the integration?**

14 A. Yes.

15 **Q. What are your concerns?**

16 A. United did a poor job of retaining PacifiCare subject matter experts and
17 preserving PacifiCare institutional knowledge. I attribute this failure to United not
18 understanding and not respecting the importance of PacifiCare experienced employees. Though
19 legacy PacifiCare leaders were included in some of the integration teams, their views were not
20 credited and were often given condescending we-know-better-than-you responses. United
21 arrogantly believed it could plunge ahead with the integration without listening to legacy
22 PacifiCare employees who knew the PacifiCare business the best. United, as the acquirer, was
23 attempting to integrate PacifiCare products, processes, and staff into the United way of doing
24 things. This required the acceptance of change by legacy PacifiCare employees. But United was
25 not effective in securing the support of legacy PacifiCare staff in successfully navigating that
26 change.

27 First, almost immediately after the acquisition closed, United announced the
28 layoffs of hundreds of legacy PacifiCare employees, intentionally shedding valuable historical

1 and institutional knowledge. As Ms. Berkel described the effect of these layoffs: “Historical
2 knowledge is intentionally severed.” (Exhibit 5265, p. 1945.) Later, in a PacifiCare lessons
3 learned document, Ms. Berkel stated that “Key acquisition resources (subject matter experts)
4 need to be retained,” and acknowledged that “Layoffs to meet synergy goals impact success of
5 long term program.” (Exhibit 644, p. 5643.) I agree with these assessments that subject matter
6 experts need to be retained as part of any successful integration, and that the layoffs of these
7 subject matter experts in the context of the PacifiCare integration negatively impacted the
8 success of the integration program. It is especially important to retain those who possess the
9 most critical knowledge relevant to the execution of a successful integration. Ms. Watson’s
10 testimony, however, indicates that the criteria governing the layoffs did not sufficiently weigh
11 the factor of critical historical knowledge. More attention should have been paid to whether
12 United had “the right people in the right spots” instead of following the “artificial exercise” of
13 aligning to United’s staffing ratios that “did not take into consideration the skill sets [PacifiCare]
14 needed.” (RT 17669-17670.)

15 As for the legacy PacifiCare employees that were not purposely laid off, United
16 failed to make adequate efforts to retain them. As Ms. Berkel explained, “PacifiCare leadership
17 retention did not adequately incent operations leadership to stay over the full period integration
18 will take” and “[r]etention did not adequately include middle management with detailed subject
19 matter expertise.” (Exhibit 5265, p. 1940.) United made the situation even worse by taking
20 away benefits from legacy PacifiCare employees post-acquisition: “All benefit changes were
21 take aways — PTO, 401(k) contributions, incentive compensation, grade/titles.” (Exhibit 5265,
22 p. 1940.) These “take aways,” Ms. Berkel observed, “incent[] FTEs to take jobs outside the
23 company.” (Exhibit 5265, p. 1943.)

24 The result was that United failed to retain key PacifiCare subject matter experts
25 who had critical institutional knowledge about PacifiCare’s processes. As of April 2007,
26 PacifiCare had lost 4,239 FTEs or 39 percent of its workforce, and 75 percent of that turnover
27 was of employees with three or more years of experience. As Ms. Berkel concluded, “we have
28 lost substantial historical knowledge across all segments, states and functions.” (Exhibit 455.)

1 For instance, Harsha Rao was a legacy PacifiCare employee, a RIMS subject
2 matter expert who had also been cross-trained to understand NDB's storage of provider
3 demographic information. (RT 130 Lippincott 15149; RT 141 Lippincott 16496.) He was thus
4 uniquely qualified to help develop and manage the EPDE process and to assist resolving EPDE-
5 related issues that arose. Mr. Rao, however, left the company around July 2007. I saw no
6 evidence that United made any efforts to retain him or to preserve his institutional knowledge
7 before he left.

8 At the very time that United was losing Mr. Rao, the IT department was also
9 refusing to allow the people on the EPDE team to contact Probir Datta, the programmer who had
10 developed the PHS Autoload program. (RT 16485.) Ms. Mimick expressed concern about
11 losing access to Mr. Datta (Exhibit 985), which Mr. Lippincott shared but did nothing to address.
12 (RT 16496-97.)

13 It is not unusual for IT departments to employ programmers to develop code and
14 then to hand off maintenance responsibilities to Operations & Maintenance staff after it is
15 deployed. But given the then-prevailing circumstances — the ongoing problems that were then
16 occurring with the EPDE process and the loss of the RIMS subject matter expert Mr. Rao — Mr.
17 Lippincott should have demanded that IT continue to make Mr. Datta available, at least on a
18 transition basis, until EPDE issues had stabilized. Instead, Mr. Lippincott acceded to IT's
19 demands not to use Mr. Datta any longer, when it should have been the other way around, IT
20 acceding to the needs of the business leaders. This created a significant gap in the institutional
21 knowledge needed for the EPDE process.

22 There is often tension between the staff of an acquiring company and the staff of
23 an acquired company, but the degree to which United disregarded and dismissed legacy
24 PacifiCare subject matter experts during the integration of PacifiCare processes was unusual.
25 This dismissive attitude likely made attempts to retain legacy PacifiCare staff more difficult and
26 likely accounted for United's inability to retain PacifiCare subject matter experts. Throughout
27 the integration process, the unavailability of institutional knowledge to explain existing
28 processes, to diagnose problems, and to help guide changes to processes hampered United's

1 ability to control, maintain, and make successful changes to these processes. As Ms. Berkel
2 complained in late 2007, “[o]ne of the struggles we have with correcting the integration mistakes
3 we made with PacifiCare is finding historical knowledge.” (Exhibit 695.) By that time, there
4 were several functional areas where PacifiCare had “very little expertise left,” and other areas
5 “where only the business representation or only the vendor is left with any knowledge of a
6 particular functional area.” (Exhibit 695, p. 5779.)

7 **C. Customer Service Breakdown**

8 **Q. Do you have any concerns about how the integration affected customer**
9 **service at PacifiCare?**

10 A. Yes.

11 **Q. What are your concerns?**

12 A. The integration had a decidedly negative effect on PacifiCare customer service.
13 Prior to the acquisition, PacifiCare was known as a “high touch” company that provided its
14 customers a high level of service.

15 But customer service complaints spiked shortly after the acquisition and remained
16 at elevated levels for long periods thereafter. External surveys gave PacifiCare and United low
17 marks for customer service, and United and PacifiCare employees, including executives,
18 complained about PacifiCare’s poor customer service following the acquisition.

19 I attribute PacifiCare’s customer service deterioration to United’s efforts to
20 abruptly align PacifiCare’s “high touch” model to its more efficiency-focused customer service
21 philosophy without preparing its customers for this change.

22 United’s outsourcing of enrollment and eligibility functions to Accenture in the
23 Philippines is one example of United’s efforts to move PacifiCare off its “high touch” model.
24 For instance, in the pre-acquisition member enrollment process, when members or employer
25 groups would submit enrollment forms that contained inaccurate information or omitted
26 information, legacy PacifiCare employees would take responsibility for ensuring that those forms
27 were corrected and processed timely. PacifiCare employees would frequently fix the
28

1 inaccuracies themselves or contact the members or employer groups to obtain the missing
2 information.

3 United regarded this practice as inefficient and expensive, and following the
4 acquisition, sought to end it. As Mr. Wichmann testified, United attempted to transition
5 PacifiCare customer service from a “defect handling unit to a defect management unit,”
6 demanding that customers “submit higher quality, more complete information about eligibility so
7 that we had a chance to process it effectively.” (RT 18459:22-18460:2.) Mr. Wichmann
8 explained that receiving higher quality, more complete information, would allow United to move
9 to a more automated process. (RT 18448:17-18449:1.) In practice, this meant that the company
10 — or by this time, Accenture workers in the Philippines — would reject and return to customers
11 (by mail) documents that contained what they deemed to be errors. Without the “high-touch”
12 assistance that customers had been accustomed to, customers would likely just re-submit the
13 forms or claims that had not yet been processed, which would add to the churn and further delay
14 processing.

15 United’s desire to automate these processes or to outsource these functions was,
16 as a general proposition, within the business discretion of its management. But the manner in
17 which United executed this drastic change — abruptly and without warning to its customers who
18 had been accustomed to a higher level of service from PacifiCare — was highly disruptive to
19 customer relations. Ignoring warnings from legacy PacifiCare employees, United failed to
20 appreciate the longstanding expectations of PacifiCare’s customers, and failed to plan for a
21 period to allow customers to adjust to the company’s different, more demanding requirements.

22 As this example illustrates, United’s lack of focus on maintaining customer
23 service — in order to achieve cost-cutting efficiencies — contributed to the severity and the
24 persistence of service problems that occurred during the integration. And even worse, because
25 United had laid off PacifiCare’s eligibility team as part of the Accenture transition, there was no
26 institutional knowledge around to help resolve customer complaints as they poured in after this
27 change. (RT 17684:15-19.) As a result, customer problems went unresolved for months. As
28

1 one employee complained, the “PacifiCare integration to date has achieved synergies at the cost
2 of excellent customer service and claims payment.” (Exhibit 450, p. 5417.)

3 **D. Failure to Appreciate and Manage Risks**

4 **Q. Do you have concerns about how United assessed and managed the risks
5 associated with integration decisions?**

6 A. Yes.

7 **Q. What are your concerns?**

8 A. United made decisions and undertook integration projects without adequately
9 assessing and managing the risks of those actions, often resulting in serious consequences.
10 Risks, of course, are attendant to any integration, but management must demand rigorous
11 analysis of those risks and must properly understand and appropriately manage them. In the
12 PacifiCare integration, however, United management sought to achieve synergies at the cost of
13 taking on unacceptably high levels of risk — in some instances unknowingly because thorough
14 analysis had not been performed. United generated various PowerPoint presentations and
15 memos that appeared to identify certain risks of taking particular actions, but I have seen no
16 evidence indicating that appropriate action was taken to manage or minimize those risks.

17 In particular, United made several decisions regarding RIMS that created risk of,
18 and in fact likely resulted in, serious claims-payment problems. RIMS, as a business-critical
19 system, needed to be closely monitored and properly maintained. In 2006, RIMS was upgraded
20 to the 3.10.70 release, but a decision had been made not to implement the current releases, 3.20
21 or 3.30, available at that time because, according to Ms. Way, “there wasn’t a business driver for
22 those two upgrades.” (RT 14207:3-7; RT 14772:18-25.) Ms. Way also testified that there was
23 no business reason for the upgrades.

24 The 3.30 version, however, was a major upgrade that would have replaced the
25 antiquated flat-file structure of RIMS with a full relational database. As I understand it, the
26 version of RIMS PacifiCare was using, and still is using, stores data in a set of flat-files — a
27 table structure, like a two-dimensional table on a piece of paper, featuring columns listing the
28 parameters (e.g., provider name, provider address, provider TIN) and rows listing the values for

1 each parameter. This type of file structure results in significant data repetition; for instance, a
2 file containing records for provider addresses and telephone numbers generally will list the
3 provider name, even though the provider name, and perhaps other provider demographics,
4 already appear in other files, containing, for example, records for the provider TIN or provider
5 contract data. Because of this organization, updating or syncing data requires changes to be
6 made in multiple files, thereby creating additional risk of errors. Changing a provider address in
7 one file does not update the same provider's address in the other files, so the updating logic must
8 know where all the files are that contain the provider name. Thus, flat-file structures are
9 inherently more prone to corruption and data errors.

10 A relational database, on the other hand, features multiple tables that are
11 organized according to relationships that exist among the data and is able to represent the various
12 kinds of relationships encountered among data. This is particularly important when there are
13 complex and varying inter-relationships among the data that must be controlled in order to
14 properly process the data. Processing health insurance claims accurately, for example, requires
15 the management and control over the inter-relationships between many data sets, such as
16 provider, patient, provider contract, provider demographics, and appropriate fee schedule.

17 A relational database has a variety of data processing advantages over a flat-file
18 structure that specially apply to healthcare data. First, a relational database cuts down on
19 duplicate data, a chronic problem in the healthcare industry. For instance, a provider name need
20 only be stored in one location and dependent fields — such as address, phone number, TIN, or
21 contract data — can simply be associated to that location. This makes updating or syncing data
22 in a relational database significantly easier and less prone to errors. A change to a provider name
23 need only occur once and it is updated in every associated field.

24 Further, data in a relational database can be accessed and updated without
25 knowledge of the specific physical location of the data by using standard structure query
26 language (SQL). The SQL command function in a relational database permits users to search for
27 and update data fields — for instance, the demographics of a particular provider — across all
28 files, automatically pulling up all records that need to be updated in a single pass. If you wanted

1 to make a change to a provider's demographics in a flat-file database, you would need to know
2 what files the provider's records were located in and exactly where in each file the records were
3 stored; and then you would need to separately change each of those files. Automating this
4 process via a COBAL program, for example, would require many more lines of code be
5 developed compared to a one- or two-line SQL command when accessing a relational model.

6 Maintaining data in a relational database is also simpler and less prone to errors.
7 The structures themselves can be modified without disrupting the pre-existing application
8 programs that use that data. Tables can be added, columns added to tables, columns rearranged
9 — any desired changes can be made without necessarily having to rewrite existing programs.

10 In addition, security is far superior on relational databases, which have the ability
11 to control or lock access at the table and row level and to create audit records of all data changes.
12 Thus, unauthorized changes to data can be avoided — which was a problem that PacifiCare
13 apparently had with RIMS (RT 15031:22-4) — and incorrect changes to the data can be tracked
14 and corrected quickly.

15 The flat-file version of RIMS that PacifiCare was using was fragile and required
16 significant manual, hands-on efforts to manage and update the data. And even with that
17 additional effort, the risk of data errors and data corruption remains far greater with a complex
18 flat-file system than with a modern relational database system.

19 Not upgrading to the relational database version of RIMS in 2005, when it was
20 available, was risky at that time, and it was inexcusable by mid-2006, given the 2006 decision to
21 abandon the June 2007 target date for migration from RIMS, and given the additional demands
22 that United was then imposing on the RIMS system after the implementation of the EPDE feed
23 in June 2006.

24 Whereas provider data previously had been manually loaded directly into RIMS,
25 under the new EPDE process, United loaded provider data into NDB and used the EPDE feed to
26 send those data to be automatically updated in RIMS. NDB itself was a relational database,
27 which meant that it stored provider data very differently than how RIMS stored the
28

1 corresponding information in its flat-file structure. The different data structures added to the risk
2 of creating data errors in RIMS during the update process.

3 Under this new process, if, say, a provider name needed to be changed, that
4 change would be input into NDB and fed down to RIMS, but the logic would need to know
5 every location in RIMS where that provider name was located and how that information was
6 used. Or, if an existing participating provider had terminated its contract with PacifiCare, the
7 EPDE logic would similarly need to know every location in RIMS where that provider existed so
8 that change could be made. And indeed shortly after the implementation of this new EPDE
9 process, there was serious corruption of the data in RIMS, such as incorrect provider
10 demographic data, providers who had terminated their contracts being listed as participating, and
11 participating providers being listed as non-participating.

12 Had United decided to upgrade to a relational database version of RIMS before
13 implementing the EPDE process, many of these problems likely could have been avoided.

14 United's decision to use the EPDE feed — which worked as data bridge
15 transferring data from one system to another — as a means to keep RIMS data updated and in
16 sync with NDB was itself also unacceptably risky. A data bridge is not an appropriate strategy
17 for true integration; it is a temporary solution for when there is no ability to manage the other
18 side of the bridge (for example, if the other side belonged to an independent entity) — which did
19 not pertain in this situation. A data bridge doesn't "integrate"; it only electronically connects
20 two systems so that data can be transferred at determined intervals. But the quality of the data
21 bridge is only as good as its last data transfer, and every data transfer presents risks of errors.

22 United should have implemented an integrated connection between RIMS and
23 NDB so that RIMS could directly access the data in NDB. As Matt Guisinger, a United VP of
24 Provider Data Integrity, commented: "If it is not a direct connect, it is a band aid. EPDE helps,
25 but would not be an end state goal — just a bridge until we can establish a direct connect if a
26 platform will be with us for a while." (Exhibit 947.) With an integrated direct connection in
27 place, the RIMS provider data files would be eliminated and RIMS would directly link to NDB
28 and use the provider data as they are stored in NDB to process claims. United's failure to build

1 an integrated direct connection between RIMS and NDB appears to have been a cost-saving
2 decision (RT 16067:21-16068:6 [direct connect would have been costly]), but it created
3 unnecessary risk in the process and likely caused and exacerbated many of the data errors in
4 RIMS.

5 United's decision to continue to operate the outdated, flat-file version of RIMS
6 throughout 2007 and 2008 (and even to this day) created even further risk — risk that United
7 was warned about but ignored. Throughout this period, internal staff was complaining that
8 RIMS had not had adequate maintenance since the acquisition, and Ms. Berkel repeatedly
9 complained about the inadequate capital allocation for RIMS.

10 By March 2008, PacifiCare was the only company in the U.S. still using the
11 RIMS version it was on; and that version was dependent upon two other long-outdated software
12 releases provided by Micro Focus and Liant Relativity. (Exhibit 655, p. 1630.) Continuing to
13 use this outdated version of RIMS with those two software releases — knowing, at that time, that
14 RIMS would still be in use for at least three more years (Exhibit 656, pp. 0204-0205) — was an
15 unacceptable assumption of risk that should not have been taken. Not only are problems more
16 likely to occur in such outdated programs, but the resolution of those problems would likely be
17 difficult because of the lack of available quality technical support. In fact, the Micro Focus and
18 Liant Relativity software releases were no longer supported by those vendors, and they needed to
19 build an environment and train staff in order to provide support for the versions of those releases
20 PacifiCare was using. (Exhibit 655, pp. 1630, 1632; Exhibit 656, p. 208.) And TriZetto initially
21 refused to extend support for RIMS beyond three years “because the risks of maintaining this old
22 product on unsupported software and platform are too high.” (Exhibit 656, p. 0208.)

23 United ultimately secured support from its vendor for its admittedly “ancient
24 version” of RIMS (Exhibit 655, p. 1627), but the quality of that support was likely sub-standard
25 since that RIMS version no longer qualified for mainstream support. When a commercial
26 product version goes off-support that means that all the mainstream developers, designers, and
27 specialists have moved on to the current, supported version. Knowledge of the old versions and
28 how to support them disappears and becomes unavailable. Further, the support people vendors

1 assigned to work on outdated releases are usually not the top performers, as those people are
2 reserved for supporting mainstream releases that most clients are using. Thus, United likely
3 received a lower tier of support for its version of RIMS than it would have received had it
4 upgraded RIMS.

5 The evidence I have reviewed indicates that internal IT support for RIMS was
6 also lacking. RIMS was a fragile, unstable system that had an unacceptable number of outages,
7 but its IT owner, Ms. Way, did not fully appreciate these problems. In an August 2007 RIMS
8 outage, for instance, IT support, led by Ms. Way, was unable to restore RIMS for four days
9 during which the entire system was down; internal sources graded IT management of the
10 recovery effort “very poor.” (Exhibit 746, p. 7172.) In addition, there were several other RIMS
11 failures that directly and negatively impacted PPO claims processing. (E.g., Exhibits 1049,
12 1055, 1056.) As Ms. Vonderhaar complained in September 2007: “This is our third RIMS event
13 within the past few weeks. I am concerned about the stability of this platform.” (Exhibit 1049,
14 p. 5224.)

15 Yet in the face of these problems and complaints from business leaders, Ms. Way
16 testified to her satisfaction with RIMS’s performance, claiming that the system was “stable” and
17 was “running fine.” (RT 18011:24-18012:13; 14207:19-23.) At the hearing, Ms. Way sponsored
18 a document that reflected that for 2007 to 2010, the “availability” of RIMS was close to 100
19 percent. (Exhibit 5466.) But it turns out that RIMS could be considered available for purposes of
20 this metric, even when the components of RIMS that process PPO claims are not functioning, as
21 long as some portion of RIMS is up and running. (RT 18310:8-18311:11.) This metric thus
22 does not accurately reflect the availability of RIMS to perform its actual function to pay claims.

23 Ms. Way also evidenced her lack of understanding of the RIMS system and its
24 maintenance in testifying steadfastly that full backups of the data had been performed on a
25 nightly basis, despite clear evidence that since the acquisition, United had failed to perform those
26 full backups (e.g., Exhibits 1044-1048). It also appears that Ms. Way was mistaken that RIMS
27 was classified as a Tier 1 application (RT 17985:6-17986:9), a designation United gives to
28

1 certain applications; when additional support for RIMS was requested, it was denied on the basis
2 that RIMS was a Tier 2 application. (Exhibit 1054.)

3 RIMS was not getting adequate support from the IT group led by someone who
4 was operating under misunderstandings such as these. Ms. Way's lack of expertise in software
5 or hardware and her lack of experience in claims administration further exacerbated the risks that
6 United was taking with RIMS.

7 **Q. Does this conclude your direct testimony?**

8 A. Yes.

Boeing A

RONALD BOEVING

Mr. Boeving is a uniquely accomplished senior technology executive with a track record of over 30 years in creating vision, identifying opportunities, building organizations, and managing large projects which fully deliver commitments. Since 2006, Mr. Boeving has been an independent management consultant offering advisory services in the strategic deployment of Information Technology resources to new and high growth businesses.

Mr. Boeving completed a fourteen-year career, ending in 2005, as Chief Information Officer of a managed care company (First Health Group) architecting and directing the technology strategies that supported growth from \$20 million to nearly \$1 billion in annual revenue. During his tenure at First Health, Mr. Boeving built the IT organization and the business processes and partnerships which consistently delivered and over-delivered the business value expected from IT investments. He earned the reputation as someone who had one of the best overall understanding of the business needs and was relied upon to identify those projects and initiatives which served those needs.

Prior to First Health, he held senior IT management roles in Pharmaceutical Manufacturing and Healthcare companies. He served the Pharmaceuticals Division of E.I. DuPont supporting human clinical trials research in the U.S., in Canada and in five European countries establishing the international infrastructure to collect data and produce the critical documentation for new drug product submissions to the FDA.

Before DuPont, he directed the IT organization for a pharmaceutical research division of American Hospital Supply Corp.

RECORD OF EXPERIENCE AND ACCOMPLISHMENTS:

BOEVING ASSOCIATES –

STRATEGIC IT MANAGEMENT CONSULTING – Lincolnshire, IL 2006 to present

President and Principal

Engagements:

-Consultant to Frazier Healthcare Ventures – Seattle, WA (2007-present)

Key Achievements:

- Due diligence assignments in support of acquisitions
- Planning and mentoring roles for CIOs of Frazier portfolio companies
- Two year engagement as acting CIO

-Acting CIO and Consultant to TridentUSA Health Services – Sparks, MD (January 2009 to January 2011)

Key Achievements:

- Led the design and achieved acceptance for a three-year IT strategic plan
- Established processes such as the corporate IT steering committee and users groups
- Established and led the corporate IT architecture group
- Developed disciplines for data and applications architecture

-IT Consultant to Omnisys Health – Greenville, TX (January 2009 to December 2009)

Key Achievements:

- Development of IT senior staff
- Budget and planning
- Risk assessment

-IT Consultant to Pentec Health – Boothwyn, PA (December 2007 to June 2008)

Key Achievements:

- Mentoring of IT group
- Assessment of IT risks and opportunities

FIRST HEALTH GROUP CORP

(acquired by Coventry Healthcare in 2005) – Downers Grove, IL

1990 to 2005

Chief Information Officer (2000-2005)

CIO and a member of the Executive Committee, reporting to the President in 2000.

Key Achievements:

- Major player in positioning First Health Group company as a premiere Managed Care Company via its enabling IT infrastructure and tools
- Oversaw the rapid and effective integration of the IT environments of five acquisitions in the last four years including:
 - ❖ CCN, a National PPO integrated with 50% staff reduction (2001)
 - ❖ CAC a 1000-person claims administration division migrated to the First Health IT standard in four months (2002)
 - ❖ HNP, a workers compensation division migrated to the First Health IT standard in four months achieving goals for synergy and economy (2003)
- Acquired a state of the art 45,000 foot data center with millions of dollars worth of brand new infrastructure for pennies on the dollar as during the dot.com demise. Parlayed this acquisition into the vehicle for consolidating six regional data centers. When completed, this project will save \$2M in operating costs per year while providing the company with sufficient space for expansion for the next five to ten years. (2003)
- Reorganized IT away from a collection of functional silos to a set of completely complementary functions with emphasis on the entire enterprise. The results have provided far superior project management and more rational architecture with far fewer design corrections plus a clearer line of command and responsibility. (2003)
- Led the effort to create a methodology to guide our rapid development to create more reliable results without compromising responsiveness. As a companion, developed the checks and balances for the methodology which ultimately assured the cooperation of all the disciplines involved in bringing new development into production. (2002)
- Organized a very rapid and complete technical refresh from the HP standard for UNIX and Storage area networks to the IBM and EMC top of the line and executed this without disruption to the business or negative impact on any ongoing IT projects. Results have yielded higher reliability and stability for lower costs. (2003)
- Utilized our flexible, expandable infrastructure to enable sales to clients desiring more automated process without making their own investments. We offer customized solutions to clients who use our imaging and customized work flow as well as our web applications to streamline their paper bogged down processes. (2002)

- Over the past five years delivered on hundreds of projects including:
 - ❖ Oracle ERP migration. Prior to Y2K deadline, converted all financials and financial management systems to Oracle including the GL, AP, AR, Purchase Order and Human Resources modules. Project duration was 9 months and came in on schedule and within budget and without significant disruption to the business.
 - ❖ FirstClaim. Redesigned and replatformed legacy Unisys manual system onto a UNIX platformed, client-server system with over 50% auto-adjudication and hundreds of new features including electronic funds transfer and unique ID management. (2002-2003)
 - ❖ Migration of our largest administration client off the legacy system and onto FirstClaim without customer disruption. (2005)
 - ❖ FrontEnd. Implemented a scanning and OCR data entry capability which processes forty million group health and workers compensation claims and bills and routes them to our back end systems. (2001-2002)
 - ❖ First/CRM. A fully proprietary customer relations management system that supported all contact on the phone including clinical management, member services, pharmacy services and provider relations. This system allowed our 24x7 staff to competently answer any and all issues in one call because it was fully integrated with our core databases. (2002)
 - ❖ First/Rx. Our system for processing pharmacy claims which currently handles 150 million per year, over 98% EDI. This system was acquired from a commercial source and integrated with our core systems including FirstClaim. (2002)
 - ❖ First Report of Injury. A highly web enabled redesign of a legacy system capable of high transaction rates and capable of being accessed from within any client site with access to the web. (2004)
 - ❖ High Availability for web installation and production system. This involved incorporating our version of ITIL into our operations and a modification of our production culture. It also required new organizational units like the TRAC team consisting of all disciplines and committed to rapid resolution of issues.

Director / Assistant Vice President / Vice President (1990 to 2000)

Upon arrival built an IT organization almost from scratch beginning with a loosely united organization of 50 generic programmers into a multi-disciplinary organization capable of satisfying the flexibility and rapid growth demands of the business. By 2001 the organization had reached nearly 500, primarily as a byproduct of the integration of IT units from acquired businesses. Rapidly integrating acquisitions became a core competency and fueled the growth of the business from \$50 million to over \$600 million.

Key Achievements:

- Developed and won support for a three-year plan to completely replace the existing infrastructure with best practices including relational database and client-server technologies. Introduced database disciplines and innovated a rapid design approach for databases involving business users and technology experts. All these efforts resulted in the database centric infrastructure that is in use today and which is ordered around the key constituencies of client, member and provider. The results from the three year plan have supported the company's growth from less than \$100M to \$900M without any significant change in infrastructure.
- Designed, developed and populated the suite of three core databases oriented to constituencies of Provider, Client and Member.
- Introduced best practice two-tier client-server technology and then replaced it with more robust three-tier client-server utilizing tuxedo middleware as the repository of business rules.
- Re-designed the utilization management system to incorporate client-server and relational database dramatically increasing automation and reducing staff.
- Built the corporate claims pricing system out of a core purchased from a commercial source and re-engineered with an Oracle database and a high capacity UNIX platform. This system processes 27 million claims per year for a variety of PPO networks and is linked to FirstClaim.
- In 1994 introduced web technology to the business with single application for locating providers which is still in use after continuous improvement. The public web site has undergone dramatic enhancements and

today provides a rich variety of services to members and clients and providers equivalent or better to that of larger competitors and complements our world class service on the telephone.

- Oversaw the IT infrastructure of the First Health TPA business acquired in 1997 by HealthCare Compare (the root company). The acquiring IT organization was barely 160 and the acquired was well over 400, but within six months there was an integrated, right-sized organization of 300.
- Built a variety of applications to supporting maintenance of databases and integration.
- Introduced data warehouses using extractions from core data and SAS data warehousing tools. Ultimately provided web based delivery of reports to clients and partners.
- Introduced EDI capability and built a core unit competency organized around data mapping and translation. This investment has driven our EDI volume and percentages for our claim processing systems and allowed us to interface with a variety of business partners.

DUPONT PHARAMACEUTICALS

(Division of E.I. DuPont) – Wilmington, DE

1987 to 1990

Corporate Manager, Information Systems

Directed staff of 35 senior IT professionals with responsibility for a budget up to \$8M.

Key Achievements:

- Developed an integrated set of specialized data bases providing support for international pharmaceutical clinical trials in Canada, the United Kingdom, France, Switzerland, Germany and Italy. Data, organized in relational databases was accessible worldwide from a U.S. located VAX cluster. Extracted data was made available to analytical tools including SAS, RS/1 and project management and modeling systems. These data were organized into the submissions to the FDA necessary to receive permission to market drug products.
- Implemented the global telecommunications network which linked sites in Europe and Canada to the U.S. Technical utilities involved global DEC/Net and X.25 protocols tying together Ethernet LANs which in turn served PCs and terminals.
- Implemented an early two-tier client-server network using Unix workstations, PCs and Macintosh units.

AMERICAN CRITICAL CARE

(Division of American Hospital Supply) – McGaw Park, IL

1979 to 1987

Director, Information Systems & Technology

Accepted a position as Project Manager supporting the discovery area research and then was promoted to Systems Manager and then Manager of Applications Development before being named Director of the technology department with responsibility for supporting all areas of the growing company.

Key Achievements:

- Designed and implemented suite of systems for data handling which addressed the functions of document management, document and graphics production and tracking and project tracking in support of drug products project management.
- Designed and implemented a sales support system which linked hospital demographics with sales data to guide sales territory allocation and pricing strategies.
- Designed and implemented financial support systems for budgeting, tracking and planning using Lotus spreadsheets linked to GL and AP mainframe systems.
- Designed and implemented integrated systems for drug product development which linked data from chromatography, stability and clinical supplies systems to the manufacturing and control systems.

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ABBOTT LABORATORIES, INC. – North Chicago, IL

1970 to 1979

Group Leader, Behavioral Pharmacology Research

Joined the cognitive research project as a pharmacologist researcher and was promoted to Assistant Project Leader, Project Leader and then Group Leader based on my professional growth and contributions in managing research.

Key Achievements:

- Contributed to more than four successful New Drug Application submissions for new Abbott drug products. Designed and oversaw a novel anti-alcohol drug model which coordinated the work of over 50 scientists and technicians.

EDUCATION AND RECOGNITIONS

Master of Business Administration

DePaul Graduate School of Business (1984)

All but dissertation for PhD

University of Memphis (1970)

Master of Science

University of Memphis (1969)

Bachelor of Science

University of Memphis (formerly Memphis State University) (1967)

External Recognition/Awards

- “Avoid the Snake Pit” presentation at Business Intelligence Forum, Phoenix, AZ, 2005
- Computerworld Premier IT Leaders, 2002
- Computerworld Premier 100. Ranked among the top 100 companies most effective in managing information, 1995
- Computerworld Client/Server Champion. Client-Server excellence in Corporate America, 1996
- InfoCare. America’s Most Computer Advanced PPOs, 1996, 1997

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Boeing B

Hearing Exhibits Reviewed

Exhibit _____
(Boeing B)

Exhibits 5-6
Exhibit 8
Exhibit 14
Exhibits 106-107
Exhibit 111
Exhibits 113-118
Exhibit 128
Exhibit 149
Exhibit 153
Exhibits 155-156
Exhibits 226-227
Exhibit 250
Exhibits 254-255
Exhibit 261
Exhibit 266
Exhibit 268
Exhibit 272
Exhibit 283
Exhibits 285-286
Exhibit 288
Exhibit 296
Exhibit 303
Exhibits 307-308
Exhibit 333
Exhibits 335-343
Exhibit 352
Exhibit 363
Exhibits 365-379
Exhibits 395-396
Exhibits 408-411
Exhibit 415
Exhibit 419
Exhibits 425-466
Exhibit 469
Exhibits 476-477
Exhibit 481

Exhibit 487
Exhibit 491
Exhibits 494-495
Exhibit 497
Exhibit 501
Exhibit 505
Exhibits 510-577
Exhibit 592
Exhibits 594-610
Exhibits 622-670
Exhibits 675-676
Exhibit 678
Exhibit 684
Exhibits 695-775
Exhibits 794-803
Exhibits 805-829
Exhibits 836-837
Exhibits 839-840
Exhibits 842-843
Exhibit 845
Exhibits 847-871
Exhibits 877-889
Exhibits 893-901
Exhibits 905-933
Exhibit 935
Exhibits 937-987
Exhibit 994
Exhibits 1026-1041
Exhibits 1044-1050
Exhibits 1054-1059
Exhibits 1062-1074
Exhibit 5040
Exhibit 5135
Exhibits 5137-5138
Exhibit 5172
Exhibit 5191

Exhibits 5223-5228
Exhibit 5243
Exhibit 5246
Exhibits 5252-5267
Exhibits 5277-5327
Exhibits 5337-5357
Exhibits 5393-5399
Exhibit 5402
Exhibit 5404
Exhibit 5416
Exhibit 5426
Exhibits 5441-5458
Exhibits 5461-5469
Exhibits 5484-5486
Exhibits 5519-5530
Exhibit 5539
Exhibits 5543-5550
Exhibit 5552
Exhibits 5555-5558

PROOF OF SERVICE

Re: *In the Matter of PacifiCare Life and Health Insurance Company*
File No. UPA 2007-00004

I am employed in the County of Los Angeles, State of California. I am over the age of 18 and not a party to the within action. My business address is 10940 Wilshire Boulevard, Suite 2000, Los Angeles, California 90024.

On, **May 27, 2011**, I served the foregoing document(s) described as **PRE-FILED DIRECT TESTIMONY OF RONALD BOEVING** on all appropriate parties in this action, as listed, by the method stated.

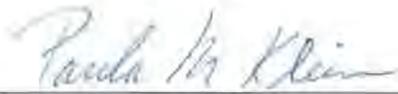
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If electronic-mail service is indicated, by causing a true copy to be sent via electronic transmission from Strumwasser & Woocher LLP's computer network in Portable Document Format (PDF) to the this date to the e-mail address(es) stated, to the attention of the person(s) named.

If U.S. Mail service is indicated, by placing this date for collection for mailing true copies in sealed envelopes, first-class postage prepaid, addressed to each person as indicated, pursuant to Code of Civil Procedure section 1013a(3). I am readily familiar with the firm's practice of collection and processing correspondence for mailing. Under that practice, it would be deposited with the U.S. Postal Service on that same day with postage thereon fully prepaid at Los Angeles, California, in the ordinary course of business. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after date of deposit for mailing contained in the affidavit.

I declare under penalty of perjury under the laws of the State of California that the above is true and correct. Executed on **May 27, 2011**, at Los Angeles, California.



Paula M. Klein