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13 BEFORE THE INSURANCE COMMISSIONER  
14 OF THE STATE OF CALIFORNIA  
15

16 In the Matter of the Accusation Against:

17  
18 **PACIFICARE LIFE AND HEALTH**  
19 **INSURANCE COMPANY**

20  
21 Respondent.  
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Case No. UPA 2007-00004

OAH No. 2009061395

**PRE-FILED DIRECT TESTIMONY OF  
TONY CIGNARALE (REVISED  
NOVEMBER 29, 2011)**

Judge: Hon. Ruth Astle

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

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1 **I. Introduction**

2 **Q. Please state your name.**

3 A. Tony Cignarale.

4 **Q. By whom are you employed?**

5 A. I am employed by the California Department of Insurance (Department or CDI).

6 **Q. What is your current position?**

7 A. I am the Deputy Commissioner of the Consumer Services and Market Conduct  
8 Branch.

9 **II. Purpose of Testimony**

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

11 A. I am presenting the Department's recommendations with regard to the  
12 appropriate penalty to be imposed on Respondent PacifiCare Life and Health Insurance  
13 Company (PLHIC or PacifiCare) under Insurance Code section 790.035 for each act in violation  
14 of Insurance Code section 790.03. I am presenting these recommendations in my capacity as the  
15 Deputy Commissioner responsible for the Department's enforcement program.

16 **III. Qualifications**

17 **Q. Is Exhibit \_\_\_\_\_ A a copy of your Curriculum Vitae that accurately**  
18 **reflects your professional experience and educational background?**

19 A. Yes.

20 **Q. In January 2006, what was your position?**

21 A. I was Chief of the Consumer Services Division.

22 **Q. To whom did you report in that position?**

23 A. I reported to Sherwood (Woody) Girion, who held the position I presently  
24 occupy.

25 **Q. Who were your direct reports at that time?**

26 A. Other than support staff, my direct reports were Jim Callahan, Chief of the Rating  
27 and Underwriting Services Bureau; Leone Tiffany, Chief of the Consumer Communications  
28 Bureau; Linda Yarber, Chief of the Consumer Education and Outreach Bureau; and Dave Stolls,

1 Chief of the Claims Services Bureau. Attached as Exhibit \_\_\_\_ B is the relevant portion of the  
2 Department's organization charts for 2007, which correctly depicts the pertinent 2006 structure.

3 **Q. What were your principal responsibilities in that position with regard to the**  
4 **allegations in this case?**

5 A. As complaints were received by the Department, they were routed to the  
6 compliance officers in the Consumer Services Division, which I directed.

7 **Q. How did your responsibilities, as they relate to the allegations in this case,**  
8 **change when you became Deputy Commissioner?**

9 A. On September 10, 2007, I assumed overall responsibility for both the Consumer  
10 Services Division, which I had headed, and the Market Conduct Division. (I had been acting in  
11 that position from August 2007.) Leone Tiffany took over my position as Chief of Consumer  
12 Services and reported to me. Market Conduct was headed by Joel Laucher, who also reported to  
13 me. In my new position I reported directly to the Chief Deputy Insurance Commissioner, who,  
14 in late 2007, I believe was Jim Richardson. Today the Chief Deputy, to whom I report directly,  
15 is Nettie Hoge, and the head of the Market Conduct Division is Pam O'Connell. Attached as  
16 Exhibit\_\_\_\_ C is an organization chart showing my Branch's structure as it was in late 2008.  
17 Exhibit\_\_\_\_ D is the current organization chart for the Branch.

18 **Q. How has your experience at the Department of Insurance equipped you to**  
19 **opine on the appropriate penalties for violations of the laws at issue in this case?**

20 A. I have been working in compliance and enforcement since I started at the  
21 Department in 1992, beginning with my service as a Compliance Officer. In that position, I was  
22 required to receive complaints from the public, assess the facts of each complaint, understand  
23 the applicable statutes, communicate with the complainant and insurer, attempt to resolve issues,  
24 and formulate recommendations when escalation was necessary. In this position, I had to  
25 identify trends in the Industry and trends at the company-specific level.

26 When I became a supervisor, my duties expanded accordingly. I assisted and supervised  
27 a group of Compliance Officers, monitored a broader range of cases, and interceded in some of  
28 the more complex, difficult, and significant cases. Identification of trends and patterns became

1 even more important because I now had principal responsibility for the thresholds for escalating  
2 issues to the Division level.

3 As Division Chief, I had a broader span of responsibility. I regularly spoke to  
4 stakeholders, including insurers and consumer groups, duties which expanded with my  
5 promotion to Deputy Commissioner. Throughout this period, I have evaluated compliance  
6 issues and formulated recommendations regarding action by the Department. In the course of  
7 those duties, I have developed an understanding of how insurance companies work, particularly  
8 with respect to the processing of claims, and of similarities and differences among companies'  
9 operations. I have gained insight into what is customary and what is abnormal, both good and  
10 bad.

11 Penalties typically become an issue once an accusation has been filed. They are  
12 discussed among the attorneys and the program staff. I have been involved in such discussions  
13 since my time as a Compliance Officer, when discussions of penalties involved cases for which I  
14 was responsible. Those discussions regularly involve the program staff up through the Division  
15 Chief and Deputy Commissioner. All settlements require approval from the Commissioner. I  
16 have frequently collaborated with the attorneys in formulating recommendations to the  
17 Commissioner regarding settlement. My input typically consists of apprising the Commissioner  
18 of my assessment of the severity of the violations, the importance of the case to the enforcement  
19 program, how the violations may relate to trends we are observing in the industry and in what we  
20 are hearing from consumers, and an assessment of the company's compliance performance.

21 **Q. Has your experience been with both health insurance and other lines?**

22 A. Yes. When I started with the Department in 1992, consumer complaints were  
23 mainly arising from the property-casualty business. At that time, health insurance represented  
24 about 5% of the complaint volume. That percentage has steadily increased. Today about 30%  
25 of the complaints we receive concern health insurance.



1 servicing of a policy or endorsement. I will then adjust the generic placement upward or  
2 downward for the specific acts in this case, depending on evidence in the nature of mitigation or  
3 aggravation, arriving at a per-act penalty (or unit penalty). This assessment will be informed by,  
4 but will not necessarily be limited to, the considerations specified in Regulation section 2695.12.

5 At the end of this process, I will review the penalties to assure that they  
6 individually and in the aggregate represent appropriate amounts to achieve the regulatory  
7 purposes of punishing the violations and deterring similar conduct in the future. I will also  
8 assess whether the aggregate penalty is appropriate in light of the licensee's financial condition  
9 and history.

10 **Q. What information will you be taking into account regarding the violations**  
11 **the Department alleges?**

12 A. I have some independent knowledge about those violations from my involvement  
13 prior to this hearing. When I consider that knowledge, I will identify it explicitly.

14 I have also reviewed limited parts of the record, and will identify when that review has  
15 proved pertinent to my recommendations. I have not, however, attempted to read the entirety of  
16 the record compiled in this hearing over the past nearly two years. Rather, I have asked the  
17 Department's counsel to summarize that evidence, from both the Department's and PacifiCare's  
18 perspective, in the form of assumptions that I will take into account in formulating my  
19 recommendations.

20 **V. Personal Involvement**

21 **Q. Are you generally aware of the Undertakings to the California Department**  
22 **that PacifiCare and United executed on December 19, 2005?**

23 A. Yes.

24 **Q. What do you know about the Undertakings?**

25 A. I recall receiving a call in the end of 2005 from Nettie Hoge, who was then a  
26 Special Assistant to the Commissioner and the Commissioner's Health Policy Advisor, and  
27 Ramon Calderon, who was then the Deputy Insurance Commissioner for the Financial  
28 Surveillance Branch. They informed me that they were working on some undertakings in

1 connection with the Commissioner's approval of the acquisition of PacifiCare. They wanted a  
2 suggestion for a metric that they might be able to use to detect a possible increase in complaints  
3 against PacifiCare. I mentioned a few possible options, which included total number of  
4 complaints and justified complaints as such possible metrics. It was a brief discussion, and we  
5 did not discuss any numeric standard.

6 **Q. What, to the best of your recollection, was the first time you became**  
7 **personally aware of the issues that led to this enforcement proceeding?**

8 A. As best I recall, my earliest involvement came in late 2006, when I got a report  
9 from Nicoleta Smith about an influx of complaints against PacifiCare. I instructed staff to  
10 follow up on these complaints, figure out how widespread the problem was, determine what the  
11 root causes were, and assess whether the complaints reflected systemic issues.

12 I also recall participating in at least one meeting with providers — it may have been a  
13 meeting with representatives of the California Medical Association or with the University of  
14 California, where the Department of Managed Health Care was also represented — in which  
15 complaints about the processing of claims by PacifiCare and United were raised. My  
16 participation in such a meeting would have been to learn about the issues they had and to  
17 encourage them to come forward with evidence of violations within the Department's  
18 jurisdiction.

19 At some point, former Commissioner Poizner received complaints from a couple of  
20 providers and asked various of his staff, including me, to inform him what was going on with  
21 respect to their complaints to the Department, which I did.

22 **Q. Were you involved in the decision to call a targeted Market Conduct**  
23 **Examination (MCE) in 2007 for PLHIC?**

24 A. No, that decision was apparently made before I had responsibility for Market  
25 Conduct. However, I would have approved the examination reports in late 2007.

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1           **Q. Do you have any basis to compare the problems encountered with PLHIC in**  
2 **2006 and 2007 to the problems you find with other companies?**

3           A. Yes. Documents that I understand have been previously marked as Exhibits 1128  
4 and 1129 are CDI's Consumer Complaint Studies for 2006 and 2007. In those studies, PLHIC  
5 had, respectively, the 20th and 18th highest number of complaints of any insurer in California.  
6 Those facts are noteworthy in part because PLHIC had so few insured lives — roughly 125,000  
7 in 2007. By comparison, for instance, Blue Shield had approximately 265,000 insured lives,  
8 about twice as many as PLHIC, but had less than half the number of justified complaints and  
9 vastly fewer violations in 2007. Blue Cross, which had almost eight times as many members, or  
10 about 975,000, had fewer justified complaints and one-fourth the number of violations in 2007.

11           In addition, in the 2008 Consumer Complaint Study, the Department found about 2.2  
12 violations per complaint filed against PacifiCare, versus an average of 0.22 violations per  
13 complaint against all insurers.

14           **Q. In the course of the Department's dealings with representatives of PLHIC in**  
15 **2006 and 2007, did you come to any conclusion whether the company was dealing**  
16 **appropriately with the issues that had arisen?**

17           A. Yes, from talking to my staff and monitoring the progress of PacifiCare's  
18 corrective actions on the issues my staff had raised with the company, I came to the clear  
19 impression that we were not getting the level of cooperation we expected, and are accustomed to  
20 getting, from insurers when a compliance issue arises. Some of the problems appeared to result  
21 from the merger. A lot of the California staff was gone, there were new layers of management,  
22 and the people who remained seemed to lack authority to speak for the company. There was an  
23 overall absence of dissatisfaction on the company's part with its own performance and with the  
24 problems that had arisen, and there was a lack of urgency about taking corrective action. Even  
25 when the company said they would fix a problem, they frequently missed the deadline.

1                   **VI. General Circumstances Surrounding the Violations Alleged**

2                   **Q. United’s acquisition of PacifiCare closed on December 21, 2005. What is**  
3 **your understanding of PacifiCare’s compliance record before the acquisition?**

4                   A. I was not aware of any particular problems with PLHIC before 2006. The  
5 Department conducted a routine market conduct examination of PLHIC for 2005-2006, the  
6 reports of which I understand to be in the evidentiary record here. My understanding is that the  
7 period covered by the exam ended after the acquisition, but before the operational changes  
8 associated with the integration took effect. There were no exceptional findings of concern.

9                   **A. Review and Approval of the Acquisition**

10                   **Q. As part of the process of reviewing the application for transfer of ownership**  
11 **of PLHIC, Commissioner Garamendi held a public hearing on November 1, 2005. Did you**  
12 **play any role in that hearing?**

13                   A. No.

14                   **Q. Please assume the following facts with regard to that hearing:**

15                                   **Executives from both PacifiCare and United appeared before the**  
16 **Commissioner and spoke. (They were not administered an oath.) They assured the**  
17 **Commissioner that “[w]e are committing to maintaining in California,” that “the vast**  
18 **majority of our employees in California will remain with the company,” that “[m]uch of**  
19 **what we do today and who does it for PacifiCare will remain in the new organization in**  
20 **California,” and that they believed it was not possible to “manage California business**  
21 **outside the state.” They state that only about 200 positions would be eliminated in**  
22 **California.**

23                                   **In January 2006, integration teams were formed and given “synergy targets”**  
24 **— positions to be eliminated. In March 2006, about three months after the acquisition**  
25 **closed, United announced the closure of mail-handling, claims operations, and customer**  
26 **service operations in California and the layoff of 600 positions, with more to follow. United**  
27 **continued to eliminate positions in the following year, and by April 2007 over 2,200 of**  
28

1 **PacifiCare’s 5,800 California positions had either been laid off or voluntarily terminated.**  
2 **Susan Berkel, Senior Vice President of Operations Integration, wrote in July 2007 that**  
3 **corporate “historical knowledge [was] intentionally severed” and expressed concern about**  
4 **the loss of subject-matter experts and that “Nil the name of synergies, it was speed to move**  
5 **and then clean.” Ruth Watson, the Vice President for Membership and Accounting,**  
6 **testified that she was told that the purpose of the California layoffs and transfer of**  
7 **positions out of California had been “to meet our synergies” that had been “promised to**  
8 **Wall Street.”**

9 **During 2006, mail and paper-claim routine was transferred from California**  
10 **to the operations in Utah and India of an outside contractor, Lason; member enrollment**  
11 **was transferred to another contractor, Accenture, in the Philippines; claims-processing was**  
12 **transferred to United operations in Texas and to another outside vendor, MedPlans, in**  
13 **Illinois, Kansas and Kentucky; the call center operation was moved to West Corp. in**  
14 **Alabama; and the printing operations were transferred to another United subsidiary,**  
15 **Duncan, in South Carolina. Major problems were subsequently encountered with the**  
16 **operations of each of these contractors, some of which are detailed below.**

17 **Nancy Monk, Senior Vice President of Regulatory Affairs, testified in this**  
18 **hearing that the statements made at the November 1 hearing were not commitments but**  
19 **merely projections that did not work out. Ms. Berkel wrote at the time that the**  
20 **commitments to regulators “have not been kept.” PacifiCare never informed the**  
21 **Department that its layoffs had exceeded the numbers its executives gave to the**  
22 **Commissioner in 2005. Ms. Berkel testified in this hearing that the concerns she expressed**  
23 **in 2007 regarding the loss of institutional knowledge and the speed of integration actually**  
24 **concerned only the HMO operations, not PPO. However, her contemporaneous documents**  
25 **in which she expressed these concerns contain no such limitation and point in part to**  
26 **deficiencies in the PPO operation. In the summer of 2007, David Wichmann, who was**  
27 **UnitedHealth Group’s Executive Vice President and Chief Financial Officer and who was**  
28 **then the United executive in charge of operations for the combined company, traveled to**

1 **PacifiCare's Cypress headquarters and spoke to the staff, saying that United had cut too**  
2 **deeply and would rebuild the staff. Mr. Wichmann himself did not deny that fact but**  
3 **testified that he did not remember saying they cut too deep.**

4 **PacifiCare points out that some legacy PacifiCare executives were retained,**  
5 **including Ms. Berkel, Ellen Vonderhaar, the Vice President of Transaction Operations, Ms.**  
6 **Watson, and Ms. Monk.**

7 **Specifically with respect to the statements made at the 2005 hearing before**  
8 **Commissioner Garamendi, and in light of subsequent developments, do those statements**  
9 **have any relevance to your penalty recommendation?**

10 A. The decision to reduce staff is not unusual in an acquisition, and I draw no  
11 negative inference from it. And as much as we might hope insurance for California customers  
12 would be handled by California employees, there is nothing illegal or improper about  
13 outsourcing, whether to employees or independent contractors in other states or overseas. Nor is  
14 there anything improper in attempting to reduce costs. However, a company that undertakes  
15 such a program to cut costs bears full responsibility for doing so without sacrificing full  
16 compliance with the law and without causing deterioration of service to its policyholders and  
17 providers that file claims.

18 The most troubling facts I have been given in this question concern the apparent lack of  
19 candor with which PacifiCare and its management have dealt with the Commissioner and the  
20 Department. If the representations that were made in November 2005 were false when made,  
21 that would be very serious. Even if the representations were true statements of management's  
22 intentions at the time, the failure to inform the Department of the company's changes in plans is  
23 a serious omission. We rely on full and forthright disclosure from insurers. We generally accept  
24 what we are told by the carriers we regulate, and that trust usually proves to be well-founded. If  
25 we cannot rely on their representations, it creates serious enforcement problems for us.

26 So I consider evidence of lack of truth and candor in communications with the  
27 Department to be a potentially significant aggravating factor.

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**B. The CTN Transition**

**Q. Please assume the following facts.**

**Prior to the acquisition, PacifiCare had a provider network numbering approximately 38,000 providers. United did not have a provider network of its own in California. Instead, it leased from an affiliate of Blue Shield access to its Care Trust Network (CTN) of approximately 46,000 providers. The U.S. Department of Justice, in its antitrust review of the acquisition, required as a condition of the acquisition going forward that United cease to use the CTN Network within a year of the acquisition closing. However, when the acquisition closed, Blue Shield gave notice it was terminating the lease in six months, as its contract permitted it to do.**

**Cancellation of the CTN lease “by definition” had only “nominal impact on PLHIC” and did not affect PLHIC members, who continued to have access to their providers in the PacifiCare network. There was, however, a provider “gap” for United, consisting of providers to whom United members required access and who were not in the PacifiCare network, which United urgently sought to remedy before losing access to the CTN network on June 23, 2006. In this hearing, and in its communications with the Department before the filing of this case, PacifiCare maintained that the termination of the CTN network, and the need to contract with 8,000 providers who were in the CTN network but not the PacifiCare network, was a major contributing factor to the claim-handling problems that were encountered starting in 2006. For example, the company blamed its failure to maintain PLHIC fee schedules on “resource issues” created by “the speedy transition to contract gap providers.”**

**However, in the course of this hearing it became clear that the scope of this urgent contracting program greatly exceeded the actual need to obtain access to the providers who would otherwise be lost following termination of the CTN lease. While United represented a need to contract with 8,000 providers, in reality, United had not had**

1 any billings from half of those 8,000 in the preceding year. PacifiCare nonetheless chose to  
2 contract with approximately 9,000 providers, although the “gap” was actually closed with  
3 fewer than 3,000 contracts.

4 **Do any of these assumptions have any relevance to your penalty**  
5 **recommendation?**

6 A. I see nothing in the cancellation of the CTN lease and United’s need to contract  
7 with the “gap” providers that would constitute a mitigating or aggravating circumstance. First, it  
8 is not clear why contracting with non-PacifiCare providers should have had any impact on  
9 PacifiCare members. In particular, it is not clear why the contracting activity should have any  
10 impact on claim-handling for PLHIC. I assume different staffs were involved in claim handling  
11 and contract negotiations, so the ability of claims personnel to process ongoing PLHIC claims  
12 should not have been affected.

13 More generally, there is nothing in these assumed facts that should operate to mitigate  
14 any penalties. Contracting with providers is a basic function for a health insurance company.  
15 While the CTN cancellation may have required prompt action, United was apparently aware in  
16 advance of the likely loss of access to that network, and United would have known that the  
17 contract it entered to obtain that access contained a six-month cancellation provision. All  
18 insurance companies, and especially those with United’s vast resources, are expected to maintain  
19 adequate capacity to perform basic functions, like maintaining the fee schedules that ensure  
20 providers are correctly paid. Moreover, the suggestion that United sacrificed the accuracy of  
21 PLHIC’s fee schedules in order to engage in a contracting effort that did not benefit PLHIC  
22 members is hardly mitigating.

23 Also troubling is further evidence of a lack of candor on the part of the company.  
24 Exaggerating to the Department the number of providers requiring new contracts, and failing to  
25 disclose that the company was also negotiating new contracts with non-gap providers is further  
26 evidence that PacifiCare did not appreciate the need for honesty in its dealings with CDI.

1           **C. Pursuit of Synergies**

2           **Q. You have already been asked to assume the facts outlined in the question that**  
3 **starts on page 8 regarding the cost-cutting measures instituted shortly after the acquisition**  
4 **closed. Please keep those assumptions in mind and assume the following additional facts.**

5           **When the integration teams formed in early 2006, they were charged with**  
6 **increasing the staffing ratios (that is, reducing staff). When they were warned that they**  
7 **were cutting too many positions too quickly, United integration staff responded that they**  
8 **knew there would be “some bumps in the road” but that United had promised Wall Street**  
9 **synergies projected at \$50 million to \$75 million in the first year and \$275 million to \$300**  
10 **million over two to three years, and had to meet those projections.**

11           **In addition to simply pruning staff, whole departments were shut down and**  
12 **their work outsourced, often hurriedly, with inadequate planning. The closed Cypress**  
13 **Mailroom was replaced by outsourcing to Lason in Utah and India. Thousands of**  
14 **documents were lost for months, and there were significant delays in processing claims and**  
15 **claim-related documents. Internal United documents laid the blame on “fragmented and**  
16 **complex” instructions for the India staff and “minimal” and “ad hoc” monitoring of**  
17 **performance. The Lason problems persisted for years. Again, the contemporaneous**  
18 **documents reflect strong dissatisfaction with Lason’s performance, but at trial the**  
19 **company’s witnesses professed satisfaction with Lason’s performance.**

20           **Similarly, the laying off of the California claim-handling staff resulted in**  
21 **PacifiCare diverting some of their work to MedPlans, a vendor with whom PacifiCare was**  
22 **already dissatisfied due to a high rate of incorrect denials and payments errors, partly**  
23 **attributable to the fact that its employees were paid on a piece-rate basis that encouraged**  
24 **them to process claims quickly rather than correctly.**

25           **United also closed the entire enrollment unit in California and outsourced its**  
26 **functions to Accenture in the Philippines. Ms. Watson, who was retained by United and**  
27 **served on one of the integration teams, testified that she warned that the outsourcing was**  
28 **moving too fast but was ignored. The result was that customers called PacifiCare’s offices**

1 with enrollment problems and there was nobody there to solve them. Patients were  
2 literally turned away at doctors' offices because they couldn't verify coverage. Ms. Watson  
3 described the consequences as "one of the most difficult service breakdowns I've ever  
4 experienced" in her 30-year career.

5 In addition to cutting staff, operations and capital budgets were sharply cut.  
6 PacifiCare staff repeatedly complained that there was no budget to carry out their work.

7 The budget for RIMS, the computer system for paying PLHIC claims, was  
8 "significantly limited given the desire to immediately recognize synergies." United formed  
9 a "Keep the Lights On" program to do "just the minimum" to keep RIMS running. By  
10 2008, PacifiCare was the only user in the country using an antiquated version of the RIMS  
11 software. Vendors threatened to discontinue support for RIMS because the risks "are too  
12 high." Ms. Berkel first admitted that RIMS was not adequately maintained, then denied it.  
13 Although Ms. Berkel complained at the time that the capital allocation for support of the  
14 claims platforms was "wholly inadequate", at the hearing she testified that IT capital  
15 resources were never constrained. Divina Way, who was in charge of RIMS maintenance,  
16 testified here that RIMS was "stable" and "running fine" despite complaints at the time  
17 that RIMS had become unstable.

18 Do any of these assumptions have any relevance for your penalty  
19 recommendation?

20 A. Yes.

21 First, the haste with which the company outsourced functions and cut staff in the  
22 pursuit of synergies, in addition to its limitations on spending for core operations, describes a  
23 "general business practice" for purposes of Insurance Code section 790.03(h). If prohibited acts  
24 flowed from that practice, they constitute unfair claims settlement practices under the code.

25 Second, the nature of the practice has implications for the required penalty. If  
26 PacifiCare was creating conditions that led to violations in the pursuit of cost savings, it is  
27 imperative that the penalty be sufficient to deter such decisions by PacifiCare and other insurers  
28 in the future. Handling claims in a compliant manner requires the commitment of sufficient

1 funds and personnel. The refusal to make that commitment must be penalized with sufficient  
2 severity that it will not prove to be a profitable business practice.

3 Third, I am again very concerned about the apparent lack of candor and honesty in  
4 the company's dealings with the Department and with this tribunal. Sworn testimony that  
5 appears to be contradicted by contemporaneous internal documents is very troubling. I assume  
6 that the Administrative Law Judge, who observed these witnesses, will draw her own  
7 conclusions about the veracity of this testimony, and I will not make any assumption about her  
8 determinations. However, if she concludes that the company's witnesses testified falsely, that  
9 would certainly be an aggravating factor, which I have not incorporated into my  
10 recommendations here.

11 **Q. PacifiCare argues that there is no evidence of specific violations being the**  
12 **product specifically of any of these practices — the layoffs, the hasty outsourcing, the lack**  
13 **of monitoring vendors, the budget constraints, and the other items you just addressed.**

14 **What is your response?**

15 A. That point misses the mark. Assuming the violations have been proved, there is  
16 no need to trace any specific violations back to a specific cause. The acts in violation — for  
17 instance, the late payment of claims — are unlawful whether they are attributable to Lason, to  
18 MedPlans, or to other practices that may not even have been discovered by the Department.

19 However, it is a reasonable inference that, for instance, Lason losing documents  
20 for months contributed to late payment of at least some claims. If there were also some claims  
21 paid late for reasons unrelated to Lason, that simply implicates other practices that may also have  
22 contributed to some late payments. PacifiCare has access to the evidence of other causes that  
23 might contradict the inferences being drawn here, but in the absence of such evidence the  
24 inferences remain sound. In my opinion that is appropriate. While causation may impact  
25 whether there were any mitigating or aggravating factors associated with a violation for penalty  
26 purposes, a requirement that each violation be traced on the record to its causative practice would  
27 be an onerous obstacle to enforcement of the law, and one that I do not see in the Insurance  
28 Code.

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**D. Undertakings, Tolerance Thresholds**

**Q. You are aware that both United and PacifiCare executed certain Undertakings in connection with the Commissioner’s approval of the acquisition in 2005. What significance do those Undertakings have for this case?**

A. None. Those were unilateral commitments by the companies, made to secure the Commissioner’s approval, which was granted. In principle, to the extent any of those commitments were not satisfied, the Department has remedies as set forth in those Undertakings for those breaches. To the extent insurers violate the law, the Department has separate provisions under the law that it is required to enforce. In reality, the problems with PacifiCare’s post-acquisition conduct were far more problematic than any breaches of the Undertakings, which is why this enforcement action was initiated.

**Q. PacifiCare points out that the timely-payment provisions of Undertaking 19 contain “tolerance thresholds,” which PacifiCare reads to reflect a concession by the Department that so long as the late payments are no more frequent than those thresholds, the Department has agreed to tolerate them. Is that consistent with your understanding?**

A. No. I see nothing in the Undertakings that would support such a conclusion. The Department does not apply “tolerance thresholds” in any enforcement actions it pursues. We expect every licensee to strive to comply with all applicable laws in every act taken, not some percentage of full-compliance. In extremely limited circumstances, the Department may, and in my experience, has in one instance, consent to the use of claim performance benchmarks in a multi-state settlement agreement with an insurer. The one instance that I recall was the multi-state settlement agreement with United in which other states first initiated the examination of United’s claims practices and then negotiated the settlement with the insurer. Thereafter, CDI signed on to the multi-state agreement.

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## VII. Specific Violations

**A. PacifiCare's Incorrect Denial of Claims Due to Failure to Maintain Certificates of Creditable Coverage on File**

**Q. Are you generally familiar with the function of certificates of creditable coverage (COCCs)?**

A. Yes. COCCs are documents that show that a member had continuous prior coverage; insurers often require new members to submit COCCs in order to cover conditions that would otherwise be excluded as pre-existing conditions.

**Q. Are you aware of the allegations that PacifiCare denied claims inappropriately due to the company's failure to maintain copies of member COCCs in violation of law?**

A. Yes.

**Q. Do such inappropriate claim denials violate sections of the Insurance Code or the Fair Claims Settlement Practices Regulations?**

A. Yes. Insurance Code sections 10123.13, subdivision (a), and 10123.147, subdivision (a), require insurers to reimburse uncontested claims within 30 working days. These claims should be treated as uncontested and promptly reimbursed because the company had the information necessary to properly adjudicate the claim. Requiring members to resubmit COCCs multiple times violates this section as well as Regulation section 2695.7, subdivision (d), which requires insurers to diligently investigate claims and not persist in seeking information not reasonably required for resolution of the claim. Each Explanation of Benefits (EOB) document that denies a claim for lack of a COCC, when the member has submitted a COCC, constitutes a violation of Insurance Code section 790.03, subdivision (h)(1), if knowingly committed or performed with such frequency as to indicate a general business practice, because it falsely represents that the member had not yet submitted and the insurer had not yet received evidence of prior coverage. Claims denied on this basis are also violations of 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. They also violate section 790.03, subdivision (h)(5), because such improper claim denials are instances in which the company is not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

1           **Q. In some cases in which a claim is inappropriately denied because of failure to**  
2 **track a COCC, no payment would have been owed even if the claim had been correctly**  
3 **processed, because the entire allowable amount would have been within the member's**  
4 **deductible. Under those circumstances, is such a denial still a violation of law?**

5           A. Yes. First, EOBs sent in connection with those claims misrepresent the insured's  
6 eligibility for coverage and request unnecessary information that the company had already  
7 received. Moreover, the failure to apply the covered amount to the member's deductible when  
8 the claim was first processed potentially has an effect on the member's total out-of-pocket  
9 contribution and the insurer's liability for future claims. This type of denial may also result in  
10 the insured not seeking necessary treatment for fear that future claims would be denied and the  
insured would be required to pay for the services out-of-pocket.

11           **Q. In general, how would you rate the severity of a claim denial on the basis of a**  
12 **pre-existing condition where the insured had already provided a COCC?**

13           A. In comparison to the range of violations to which section 790.035 applies, I view  
14 this kind of violation as very serious. Inappropriate claim denials can cause a patient to be  
15 denied medical care or to avoid needed care because the patient cannot afford to pay for the  
16 treatment. These violations therefore present a risk of bodily injury or degradation of health. In  
17 my experience, the members who are most likely to experience a claim denial related to a failure  
18 to maintain COCCs are those with significant chronic health problems, and those consumers are  
the ones who are most vulnerable to the denial or postponement of medical care.

19           **Q. Where do you place this type of violation on the section 790.035 spectrum**  
20 **from zero to either \$5,000 or \$10,000 per act in violation?**

21           A. Because it has such serious consequences for consumers, I would set it at 65% of  
22 the penalty range: \$3,250 for a non-willful violation, and \$6,500 if the violation is willful.

23           **Q. Should violations where no payment is owed to the provider be penalized at**  
24 **this level?**

25           A. I view these violations as less serious than COCC violations that encompass  
26 denied or delayed payment to the provider, but still of average seriousness when compared to  
27 the full range of violations of section 790.03. The member will suffer the same consequences as  
28 if the deductible had already been met and monetary payment was owed: knowledge that his or  
her health condition will not be covered, and the risk of being unable to access needed care as a

1 result. However, given that this type of violation does not present the same degree of harm to  
2 the provider, this subcategory of violations should be penalized at 50% of the penalty range:  
3 \$2,500 for a non-willful violation, and \$5,000 if the violation is willful.

4 **Q. Would your assessment of the penalty be influenced by evidence that some of**  
5 **PacifiCare’s problems processing COCCs began before the acquisition by United?**

6 A. No. PacifiCare is the licensee and has an obligation to comply with the laws,  
7 regardless of its ownership structure. Evidence that a particular violation was caused, in whole  
8 or in part, by reckless integration practices after the acquisition might be relevant to some of the  
9 penalty factors, but evidence of problems that pre-date the merger is neither a mitigating nor  
10 aggravating factor per se.

11 **Q. Now, let me describe for you the background on these particular COCC**  
12 **related claim denials. Please assume the following facts:**

13 **As you are aware, insurers are permitted to deny certain claims based on the**  
14 **pre-existing conditions exclusion unless the member had continuous coverage. COCCs are**  
15 **insurance documents that insurers typically request members submit in order to**  
16 **demonstrate that the member had continuous coverage. When PacifiCare received a claim**  
17 **from a new member with a treatment code that corresponded to a pre-existing condition,**  
18 **and the company’s claims adjudication system — known as RIMS or QicLink — did not**  
19 **show that the member had a COCC on file, the claim would be closed or denied and the**  
20 **member would receive a denial letter. Members would be asked to submit COCCs to**  
21 **PacifiCare, which they often would send by facsimile or by mail. When received, a COCC**  
22 **was supposed to have been sent to a PacifiCare claims team to reprocess the denied claim**  
23 **and to update the member’s record in RIMS so that future claims would be covered. The**  
24 **COCC was then supposed to have been scanned as a “secondary document” and**  
25 **permanently stored in PacifiCare’s long-term filing system. By 2006, Lason, the vendor**  
26 **that had assumed mailroom and document routing functions, was supposed to index**  
27 **COCCs by claim number so they could be retrieved, if necessary.**

28 **In October 2006, CDI began receiving a large number of complaints from**  
**PacifiCare members that they had submitted COCCs but were continuing to have their**  
**claims denied on the basis of pre-existing conditions. Around the same time, regulators**  
**from Washington and Oregon independently began investigating problems related to**

1 PacifiCare's failure to maintain COCCs, which, as Mr. McMahon observed, indicated a  
2 "systemic problem" with COCC handling. PLHIC members reported being asked to  
3 submit, then re-submit, copies of their COCCs multiple times. Some of these members also  
4 reported that prior claims had been paid once they submitted a COCC, but subsequent  
5 claims for the same treatment were being denied. Consumers reported feeling worried and  
6 frustrated by these denials because of the "threat of financial responsibility" for needed  
7 treatments, compounded by PacifiCare's lack of responsiveness to consumer calls. Nicoleta  
8 Smith raised the COCC issue with PacifiCare's general counsel in December 2006 and  
9 notified PacifiCare of suspected deficiencies in its COCC tracking process by letter in  
10 January 2007.

11 In early 2007, following a telephone conference with CDI staff, PacifiCare  
12 claimed to initiate a corrective action plan for tracking COCCs, including establishing a  
13 database to track all COCCs received by the company. PacifiCare ultimately disclosed to  
14 CDI that 1,799 claims had been incorrectly denied on the basis of pre-existing conditions  
15 due to failure to track COCCs, and provided documentation of those claims. PacifiCare  
16 assigned a team to rework those affected claims, paying a total of \$765,157 for 689  
17 improperly denied claims. The remaining 1,110 claims required no additional payment,  
18 because the covered amount was within the member's deductible. However, PacifiCare did  
19 not provide documentation of a process to calculate when the members' deductible would  
20 have been met but for the improper denial and reprocess of any subsequent claims. In  
21 April 2007, PacifiCare implemented a "retrospective claim review" whereby receipt of a  
22 COCC would trigger review of all prior claims received from the member that may have  
23 been denied on a pre-existing condition basis. PacifiCare began disseminating a "welcome  
24 letter" to new members in October 2007 (for members enrolled by paper) and March 2008  
25 (for members enrolled electronically) requesting COCCs, so that the forms would be on file  
26 before claims were submitted.

27 The COCC tracking issues can be traced to several flaws in the integration of  
28 PacifiCare into United. In the first half of 2006, much of PacifiCare's Cypress staff was  
laid off. In some departments, such as Group Services, many fax machines were simply left  
unattended when the staff assigned to them were laid off. COCCs that were faxed to  
PacifiCare may have been ignored by the company for this reason. To this day, PacifiCare

1 still does not have a consistent method for handling incoming faxes. PacifiCare has also  
2 acknowledged that the company lacked the capacity to share COCCs between different  
3 departments “or keep them entered in a central location for all staff to review. Or they are  
4 simply ‘lost’”

5 Prior to PacifiCare’s acquisition by United, a COCC received by mail would  
6 be routed to that team by an experienced mail sorter at PacifiCare’s Cypress office. In  
7 July 2006, the mail routing function was outsourced to a company called Lason, which also  
8 took over scanning and storage of secondary documents. COCCs sent through the mail  
9 were routed to PacifiCare staff through Lason’s DocDNA system. However, the document  
10 routing rules provided to Lason were “fragmented,” “lengthy and complex.” Documents  
11 were improperly coded over 30% of the time and were frequently lost and misrouted.  
12 According to PacifiCare’s internal documents, DocDNA queues and inventory were  
13 “poorly managed”, and it sometimes took two weeks for a document to reach its  
14 destination. Even after reaching the appropriate queue, documents were not timely  
15 processed. In one instance, 14,000 documents that should have been transmitted to  
16 PacifiCare claims rework staff, which may have included COCCs, were “locked” in  
17 DocDNA over a four-month period. PacifiCare did not detect the buildup because it lacked  
18 proper reconciliation mechanisms.

19 While documents were being routed in the DocDNA system, there was no  
20 way to search for them by member number or claim number, even though PacifiCare had  
21 anticipated that misrouting would occur. The cost of making documents searchable within  
22 DocDNA was only \$40,000, but this improvement was initially rejected because “it isn’t in  
23 the budget.” As a result, if a COCC was “lost” in DocDNA, and the member called and  
24 explained that he or she had already sent it, the customer service representative would  
25 have no way to search in DocDNA to confirm it, so the member would likely be told to send  
26 it again. Ms. Berkel agreed that it was “ridiculous” and an “integration mistake” to “route  
27 documents through a tool with no way to search for them.” PacifiCare eventually  
28 improved DocDNA to include this search function.

There were also problems with Lason’s handling of COCCs after they had  
been used to adjudicate a particular claim and became “secondary documents.” In  
December 2006, PacifiCare noted that providers were being asked to send the same

1 document multiple times because Lason was not indexing the document when first  
2 received. PacifiCare discovered in August 2007 that Lason had failed to index over 9,000  
3 PPO-related documents by a claim number or member number. This error was attributed  
4 to PacifiCare's failure to provide processing instructions for secondary documents, lack of  
5 a consistent process for transmitting secondary documents to Lason, and failure to provide  
6 a procedure for Lason to reject documents that were submitted with incomplete  
7 information. As PacifiCare described it, "Secondary Document indexing was in a black  
8 hole."

9 These document handling problems are traceable, at least in part, to the  
10 following business practices associated with the transition to Lason. Implementation of  
11 DocDNA was rushed and accompanied by inadequate testing and training and insufficient  
12 quality control and reconciliation measures. In creating DocDNA, PacifiCare "designed  
13 something so complicated it was difficult to manage" and "didn't give [Lason] the best  
14 direction." Accountability within PacifiCare for functions outsourced to Lason was  
15 fractured and incomplete, with no oversight of the secondary document indexing function.  
16 PacifiCare neither established nor held Lason accountable for quality metrics in service  
17 level agreements.

18 Although the transition to Lason resulted in significant problems in the  
19 second half of 2006, PacifiCare did not set out to comprehensively address Lason's  
20 performance problems until October 2007, and did not redesign the overly complex  
21 document routing rules, develop a scorecard to track Lason's document handling  
22 performance, or implement new quality guarantees in Lason's contract until the Spring of  
23 2008. PacifiCare did not begin conducting regular quality audits until long after problems  
24 with Lason's performance became evident. For example, a month after PacifiCare noted,  
25 for the second time, that Lason was not properly indexing secondary documents,  
26 PacifiCare was still not performing a quality audit of that function.

27 PacifiCare contends that the manual mail distribution system that existed  
28 prior to the merger was inherently error-prone and not susceptible to rigorous oversight,  
but there is no evidence of pre-merger mail distribution problems. PacifiCare has also  
pointed out that some of the problems tracking COCCs pre-dated the merger, but

1 **acknowledges that the COCC violations are partly attributable to the integration problems**  
2 **with Lason.**

3 **First, given this information, were these acts knowingly committed or**  
4 **performed with such frequency as to indicate a general business practice?**

5 A. Yes. “Knowingly committed” as defined by Regulation section 2695.2,  
6 subdivision (/), means “performed with actual, implied or constructive knowledge, including,  
7 but not limited to, that which is implied by operation of law.” PacifiCare knew or should have  
8 known that it was misrepresenting to claimants pertinent facts relating to coverage, i.e., it knew  
9 or should have known that the claim denials were incorrect. PacifiCare is chargeable with  
10 constructive knowledge of documents it has received from claimants, so failures to act on the  
11 basis of those documents are knowingly committed. For these same reasons, PacifiCare  
12 knowingly did not attempt in good faith to effectuate prompt, fair, and equitable settlement of  
13 claims in which liability has become reasonably clear. PacifiCare also had sufficient  
14 information to be chargeable with knowledge that it needed to have in place sufficient processes  
15 to ensure that important documents like COCCs would be adequately routed, maintained, and  
16 stored. By failing to implement adequate procedures, or failing to ensure that its vendor  
17 implemented such procedures, PacifiCare knowingly failed to adopt and implement reasonable  
18 standards for the prompt investigation and processing of claims.

18 **Q. As you know, Insurance Code section 790.035, subdivision (a), states that**  
19 **“when the issuance, amendment, or servicing of a policy or endorsement is inadvertent, all**  
20 **of those acts shall be a single act for the purpose of this section.” Does this provision apply**  
21 **to these COCC denials such that they all should be treated as a single act?**

22 A. No. These claim denials do not constitute the inadvertent “issuance, amendment,  
23 or servicing of a policy or endorsement.” Obviously, there was no issuance or amendment here.  
24 By denying a claim — that is to say by sending out a denial letter or an EOB that denies the  
25 claim — PacifiCare was “servicing” the policy, but there is no evidence that that act of servicing  
26 was inadvertent. When the insurer intends to process and deny a claim but does so wrongfully  
27 or incorrectly, that does not constitute the inadvertent servicing of a policy for purposes of  
28 determining the number of acts in violation. In this instance, PacifiCare did not inadvertently  
send out these denial letters or EOBs.

1           **Q. But what if the COCCs at issue in these claim denials were lost by accident.**  
2           **Does that mean that the servicing of the policy was inadvertent?**

3           A. No. Section 790.035 doesn't say when a potential cause that may have led to the  
4 acts in violation was inadvertent, all of those acts shall be a single act. It says when the  
5 servicing of the policy is inadvertent, all of those specific acts of servicing that were in violation  
6 shall be a single act. Here, the specific acts of servicing the policy sought to be penalized —  
7 i.e., the sending out of the claim denials — was not inadvertent. Evidence of the contributing  
8 causes of the act in violation may be relevant to assessing whether an unfair act or practice is  
9 willful, as well as to the penalty factors under Regulation 2695.12, but not to whether the  
10 issuance, amendment, or servicing of policy was inadvertent.

11           **Q. As you know, section 790.035 authorizes civil penalties for “any unfair or**  
12 **deceptive act or practice defined in section 790.03” up to \$5,000 for each act or if the act or**  
13 **practice is willful, up to \$10,000. Given the background information for these violations, do**  
14 **you classify these improper claim denial violations as willful or non-willful?**

15           A. Yes, these are willful violations.

16                     First, Regulation section 2695.2, subdivision (y), defines “willful” and “willfully”  
17 as:

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

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

25                     There are several unfair practices that PacifiCare committed with “purpose or  
26 willingness” in connection with these COCC-based denials. Under the assumptions I have been  
27 given, these wrongfully denied claims are the result of PacifiCare’s purposeful or willing failure  
28 to adopt and implement reasonable standards for the prompt investigation and processing of

1 claims. (Section 790.03, subdivision (h)(3).) Such reasonable standards include careful  
2 consideration, when designing operational systems, of possible claims-handling and regulatory  
3 consequences; comprehensive testing, error detection and quality control; close supervision of  
4 vendors performing outsourced work; and rapid responses to signals that systems are not  
5 performing as expected. Any reasonable insurer would know that it must have processes in  
6 place to assure accurate and consistent handling of COCCs, given their importance to claim  
7 processing. PacifiCare admitted that it did not implement a system for keeping COCCs in a  
8 central location where staff could access them, and it evidently failed to adopt a system for  
9 maintaining COCC data accurately in RIMS.

10 With respect to Lason, PacifiCare transferred responsibility for crucial documents  
11 to an outside vendor, designed “something so complicated it was difficult to manage,” and then  
12 failed to adequately monitor the outsourced work. The company provided inadequate  
13 instructions or no instructions at all; did not timely implement common quality control  
14 mechanisms like reconciliation reports, audits, and performance payment guarantees; and routed  
15 the documents through a system that could not be searched despite knowing or having reason to  
16 know such searches were required to process claims correctly.

17 PacifiCare also, with purpose or willingness, misrepresented pertinent facts.  
18 (Section 790.03(h)(1).) PacifiCare has an institutional policy of denying claims for what it  
19 believes to be pre-existing conditions, unless the claims examiner is aware that a COCC has been  
20 received. By October 2006 at the latest, PacifiCare’s top leaders were aware of a “systemic  
21 problem” processing COCCs, and should have known that RIMS did not reliably reflect whether  
22 a COCC had or had not been sent. Each time it issued, through its claim examiners, an EOB  
23 denying the claim as a pre-existing condition, the company exhibited a willingness to  
24 misrepresent pertinent facts to providers and members.

25 **Q. So your baseline penalty per act in violation of this provision is 65% of**  
26 **\$10,000, or \$6,500, for the 689 claims in which payment was owed to the provider, and 50%**  
27 **of \$10,000, or \$5,000, for the remaining 1,110 claims?**

28 A. Yes.

1           **Q.     Now, in light of the facts you have been asked to assume and the factors**  
2 **enumerated in section 2695.12, what penalty would you propose for this category of alleged**  
3 **violations?**

4           A.     First, I have seen no evidence of the existence of extraordinary circumstances  
5 (Reg. § 2695.12, subd. (a)(1)), which are defined by the Regulations to mean “circumstances  
6 outside of the control of the licensee which severely and materially affect the licensee’s ability  
7 to conduct normal business operations” (Reg. § 2695.2, subd. (e)).

8           There is no evidence that PacifiCare had a good faith and reasonable basis to  
9 believe that any of the allegedly mishandled claims in this action were fraudulent and that the  
10 company reported that information to the Department. (Reg. § 2695.12, subd. (a)(2), citing Ins.  
11 Code, § 1872.4.) Unless I am told otherwise, I will assume that this factor is not relevant to the  
12 penalty determination in this case. Likewise, Regulation 2695.12, subdivision (a)(4), which  
13 considers whether there was a “gross exaggeration of the value of the property or severity of the  
14 injury, or amount of damages incurred”; subdivision (a)(5), concerning whether there is  
15 “substantial mischaracterization of the circumstances surrounding the loss or the alleged default  
16 of the principal”; subdivision (a)(6), regarding the “secreting of property which has been claimed  
17 as lost or destroyed”; and subdivision (a)(14), concerning “the licensee’s reasonable mistakes or  
18 opinions as to valuation of property, losses or damages” are relevant to other lines of insurance  
19 business, such as property and casualty, but generally not to health insurance. I will disregard  
20 these factors in my penalty assessment unless the assumptions provided suggest that they bear on  
21 this case.

22           The complexity of the underlying claims would be a slightly mitigating factor if the  
23 violations were attributable, at least in part, to that complexity. (Reg. § 2695.12, subd. (a)(3).)  
24 Claims subject to pre-existing conditions are fairly complex. The breakdown here, however, was  
25 not caused by the inherent difficulty in processing the pre-existing condition. Therefore, I see no  
26 aggravating or mitigating factors here based on complexity.

27           The relative number of the claims where the noncomplying acts were found to exist  
28 is not applicable for this set of violations. (Reg. § 2695.12, subd. (a)(7).) This factor requires

1 consideration of the number of claims where violations have been found compared to the number  
2 of claims reviewed by the Department. In this instance, PacifiCare identified the affected claims  
3 and the Department did not review claims other than those that contained these COCC  
4 violations.

5 There is evidence that PacifiCare undertook remedial measures with respect to  
6 these claims. (Reg. § 2695.12, subd. (a)(8).) PacifiCare self-identified the number of affected  
7 claims and reprocessed them fairly promptly. I also took into consideration that PacifiCare  
8 eventually remediated some of the Lason issues that were contributing to COCC-based denials.  
9 But the fact that PacifiCare has still not put in place a consistent process for handling incoming  
10 faxes is also troubling. Overall, however, this factor is mitigating.

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

20 Compared to the type of harm that typically flows from this type of violation, the  
21 COCC-based improper denials in this case appear to be more harmful. (Reg. § 2695.12, subd.  
22 (a)(10).) First, consumers faced the prospect of shouldering a financial burden that should have  
23 been covered by their insurance, which here was higher than the typical case. Of the denied  
24 claims for which money was owed the claimant, the average payment was over \$1,000. That is a  
25 significant sum for most families in California, and one that is likely to deter many patients from  
26 seeking needed care. In addition, members were harmed more than in the usual case because  
27 they were required to spend time and effort mailing or faxing multiple copies of their COCCs  
28 that they had already submitted. Typically, I would expect insurers not to require members send

1 in identical information multiple times in order to get claims processed correctly. Members were  
2 also forced to make repeated calls to PacifiCare customer service representatives who were  
3 unable to help them because their COCCs were not retrievable from within PacifiCare's systems.

4 Under the totality of the circumstances, I do not believe PacifiCare exhibited a good  
5 faith attempt to comply with these Regulations. (Reg. § 2695.12, subd. (a)(11).) As discussed  
6 previously, I do give credit to PacifiCare for remediating these incorrectly denied claims fairly  
7 promptly after being notified of these issues. But at the same time, these violations were the  
8 result of integration practices that created a serious and foreseeable risk of violations. PacifiCare  
9 neglected to assure that basic functions essential to the operation of any insurance company —  
10 monitoring incoming correspondence — were maintained during the integration. Moreover,  
11 there is evidence that PacifiCare resisted implementing cost-effective solutions because they  
12 weren't "in the budget."

13 Incorrectly denying 1,799 claims because of a failure to maintain COCCs reflects a  
14 higher-than-normal frequency for these types of violations. As discussed before, the detriment  
15 to the public caused by these violations was more severe than the typical case. (Reg. § 2695.12,  
16 subd. (a)(12).) This factor is slightly aggravating.

17 PacifiCare was apprised of facts that should have alerted them to a systemic  
18 problem with COCC handling in late 2006, when three different state regulators began  
19 investigating COCC-related claim denials. Around that time, PacifiCare also noted problems  
20 with Lason's processing of incoming mail and secondary documents. (Reg. § 2695.12, subd.  
21 (a)(13).) But the company did not establish appropriate controls over the mail routing functions  
22 outsourced to Lason until 2008. That delay is unacceptable and represents an aggravating factor.

23 Considering these factors together, I believe these factors demonstrate slightly  
24 aggravating circumstances. I therefore think it appropriate to increase the penalty by 10%, from  
25 \$5,000 to \$5,500 for the 1,110 improper COCC-based denials for which the full allowed amount  
26 was applied to the deductible, and from \$6,500 to \$7,150 for the 689 improper COCC-based

1 denials that resulted in additional payment. Therefore, my recommended aggregate  
2 penalty for this category is \$11,031,350.

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

5 **Q. Are you aware of the allegations that PacifiCare applied a twelve-month pre-**  
6 **existing condition exclusionary period in violation of law?**

7 A. Yes.

8 **Q. Do claim denials based on pre-existing condition exclusionary periods longer**  
9 **than six months violate the Insurance Code or the Fair Claims Settlement Practices**  
10 **Regulations?**

11 A. Yes, in many cases. Insurance Code section 10708, subdivision (a), limits the  
12 pre-existing exclusionary period to six months for group policies, and section 10198.7,  
13 subdivision (a), imposes the same limit for individual policies with three or more participants.  
14 For members insured under such plans, a claim denial based on a longer exclusionary period  
15 violates the insurer's obligation under Regulation 2695.4, subdivision (a), to disclose all benefits  
16 and coverage under the policy. Claim denials based on a pre-existing exclusionary period longer  
17 than six months also violate Insurance Code section 790.03, subdivision (h)(1), if knowingly  
18 committed or performed with such frequency as to indicate a general business practice, because  
19 the notice of denial misrepresents a pertinent fact related to coverage. Such denials also violate  
20 section 790.03, subdivision (h)(3), because they reflect failures to adopt and implement  
21 reasonable standards for prompt investigation and processing of claims arising under insurance  
22 policies. They also violate section 790.03, subdivision (h)(5), because such improper claim  
23 denials are instances in which the company is not attempting in good faith to effectuate prompt,  
24 fair, and equitable settlements of claims in which liability has become reasonably clear.

24 **Q. In general, how would you rate the severity of a claim denial based on an**  
25 **improper pre-existing exclusionary period?**

26 A. In comparison to the range of violations to which section 790.035 applies, I view  
27 this type of violation as very serious. Inappropriate claim denials directly harm claimants, and  
28 can even lead to patients deferring needed medical care because the financial burden of paying

1 for the care is beyond the patient's means. These violations therefore carry a serious risk of  
2 bodily injury or deterioration in health. Moreover, in my experience the members most  
3 frequently affected by such denials are those with chronic or serious health conditions, for whom  
4 such inappropriate denials may result in the most harm.

5 **Q. Where do you place this type of violation on the section 790.035 spectrum**  
6 **from zero to either \$5,000 or \$10,000 per act in violation?**

7 A. Because of the significant health consequences for consumers, I would set it at  
8 65% of the penalty range, or \$3,250 for a non-willful act in violation and \$6,500 for a willful act  
9 in violation.

10 **Q. For some of these illegally denied claims, no payment was owed to the**  
11 **claimant, which may be because the full amount was applied to the deductible or because**  
12 **the company denied the claim on an alternative basis. Should such violations be penalized**  
13 **at this level?**

14 A. I view these violations as less serious than violations that encompass denied or  
15 delayed payment. For claims that the insurer owed additional amounts that were applied to the  
16 deductible, the harm to the member is the same, but there is not the same degree of harm to the  
17 provider, as previously discussed. Under those circumstances, I view the violation as being of  
18 average seriousness and believe the penalty for a generic violation should be at 50% of the  
19 maximum. For claims that the company denied on alternative, and presumably valid, grounds,  
20 the company's initial denial based on an illegal pre-existing condition period is a  
21 misrepresentation of pertinent fact that may result in member and provider confusion, and may  
22 prevent the member or provider from submitting other, valid claims because of the mistaken  
23 belief they would be denied on pre-existing conditions grounds. Nevertheless, I recognize that  
24 the harm occasioned by these types of illegally denied claims is less severe than when additional  
25 payment is owed. I view it as the company's obligation to establish the existence of other  
26 grounds to deny the claim, so I propose to treat all the violations where no payment was due at  
27 50% but would agree to lower the penalty to 30% for those claims where the company can  
28 establish such grounds. Therefore, any violations that fit this circumstance should be penalized  
at 50% of the maximum: \$2,500 for non-willful acts in violation and \$5,000 for willful acts in  
violation.

1           **Q.     Now, let me describe for you the background on these particular violations.**  
2 **Please assume the following facts:**

3                   **As you know, a pre-existing condition provision in an insurance policy**  
4 **“excludes coverage for charges or expenses incurred during a specified period following the**  
5 **insured’s effective date of coverage, as to a condition for which medical advice, diagnosis,**  
6 **care or treatment was recommended or received during a specified period immediately**  
7 **preceding the effective date of coverage.” (Ins. Code, § 10198.6, subd. (c).)**

8                   **Beginning in 2004, certain of PacifiCare’s form policies and certificates of**  
9 **coverage contained an illegal twelve-month exclusionary period for pre-existing conditions**  
10 **rather than the six-month period permitted by law. Ms. Monk testified that the employee**  
11 **who drafted the large group policy simply made a mistake, noting that the company’s small**  
12 **group policy had the correct six-month exclusionary period. But Ms. Monk also**  
13 **acknowledged that PacifiCare does not have a procedure for having policy certificates**  
14 **reviewed by a second staff member before being filed with CDI. PacifiCare’s form policy**  
15 **containing the incorrect pre-existing condition exclusionary period was submitted to CDI**  
16 **for approval in 2004, and an amended policy was submitted in 2005. The Department’s**  
17 **review did not discover the illegal exclusionary period in either submission, and the policies**  
18 **were authorized. After authorization, PacifiCare claims that it simply assumed that all**  
19 **information contained in the certificate was correct. PacifiCare claims examiners, who**  
20 **were supposedly trained in the Insurance Code and Regulations, repeatedly applied the**  
21 **twelve-month exclusionary period while processing claims under these policies.**

22                   **In late 2006, in response to inquiries by the Department regarding consumer**  
23 **complaints of improper denials based on lost COCCs, PacifiCare disclosed that it was**  
24 **using a policy that provided for a twelve-month pre-existing exclusionary period.**  
25 **PacifiCare claims it promptly updated RIMS to set six months as the maximum**  
26 **exclusionary period, and further claims that the company began reprocessing the 3,862**  
27 **PLHIC PPO claims that had been adjudicated in 2006 and denied on pre-existing**  
28 **conditions grounds more than six months after the insured’s effective date. In March 2007,**

1 **PacifiCare amended its large group policy to include the legally permissible six-month**  
2 **exclusionary period and sent letters to employers and brokers notifying them of the new**  
3 **policy. PacifiCare completed the rework of the 3,862 claims in April 2007.**

4 **During the 2007 MCE, CM examiners uncovered further problems with**  
5 **PacifiCare’s pre-existing condition policies. For example, none of the claim files reviewed**  
6 **by examiners revealed how claims examiners had calculated the exclusionary period. In**  
7 **some cases, medical records did not support a finding that the member had obtained**  
8 **medical advice, diagnosis, care or treatment during the six months prior to coverage, yet**  
9 **PacifiCare determined the condition to be pre-existing. PacifiCare also failed to document**  
10 **the hire date of some insureds, which it admitted “prevents the accurate determination of**  
11 **the pre-existing waiting period.” Ms. Monk acknowledged that PacifiCare lacked “a good**  
12 **systematic way” to consistently obtain date of hire information from employer groups.**

13 **In late 2007 and early 2008, PacifiCare revised and updated the pre-existing**  
14 **remark codes appearing on EOBs; created a Corrective Action Team specific to pre-**  
15 **existing condition policies; and instituted ongoing weekly audits of claims denied under the**  
16 **pre-existing condition exclusionary policy. In February 2008, PacifiCare reprocessed pre-**  
17 **existing condition claim denials from 2004 and 2005, identifying 626 claims in which**  
18 **payment was owed. In April 2008, PacifiCare launched a process to track the date of hire**  
19 **of new enrollees, including outreach to obtain missing information about hire dates and**  
20 **any employer-imposed waiting periods. PacifiCare also required that MedPlans, its vendor**  
21 **responsible for processing PPO claims, create a dedicated team for processing claims**  
22 **involving pre-existing conditions and created an internal team dedicated to rework those**  
23 **claims.**

24 **PacifiCare’s audits in 2008, however, revealed that its application of the pre-**  
25 **existing condition exclusion was still resulting in many erroneously denied claims. Even**  
26 **though processing pre-existing conditions claims is “extremely complicated,” according to**  
27 **Ms. Vonderhaar, these claims were among those outsourced to MedPlans, which**  
28 **PacifiCare noted was not satisfying quality standards as to even simpler claims. The high**

1 error rates in processing pre-existing condition claims were attributable to MedPlans,  
2 whose claims examiners had received training but were not applying it correctly. Because  
3 MedPlans claims processors were paid on piece-rate basis, that is to say, paid by the  
4 number of claims they processed, PacifiCare suspected that MedPlans staff were taking the  
5 easy way out by denying claims instead of processing them with appropriate care.  
6 PacifiCare eventually instituted financial incentives for MedPlans staff to meet quality  
7 goals, but kept the pay-by-claim model intact.

8 The Department urged PacifiCare to suspend application of its pre-existing  
9 exclusionary policy to members for whom it lacked prior insurance information until the  
10 company could demonstrate that it was appropriately adjudicating claims involving pre-  
11 existing conditions. PacifiCare refused to do so, but offered to “grandfather” in any  
12 members who had joined in the last few months, waiving denial of pre-existing conditions  
13 claims for those members, at a cost of approximately \$800,000. As to future enrollees,  
14 PacifiCare would insist that brokers obtain an invoice from the prior insurer for any  
15 employer groups switching over their employees en masse from another carrier, and would  
16 decline to apply the exclusionary period for any employee listed on the prior month invoice.  
17 The Department found the proposed corrective action insufficient, and PacifiCare decided  
18 not to “grandfather” any existing members.

19 In Summer 2008, PacifiCare began using a system called AS400 to ensure  
20 that the pre-existing condition exclusionary period was not applied to members previously  
21 enrolled in a different PacifiCare plan. In July 2008, PacifiCare also reworked an  
22 additional 3,030 claims that the company had denied between October 2006 and March  
23 2008 based on pre-existing conditions grounds; this rework project resulted in PacifiCare  
24 having to make additional payments on 826 claims. By this time, PacifiCare had  
25 implemented the revised form policies setting forth the correct six-month period, but its  
26 examiners were still improperly applying the pre-existing condition exclusion to those  
27 claims.

1                   **Between 2004 and 2008, PacifiCare incorrectly denied at least 5,314 claims**  
2 **based on unlawful application of the pre-existing condition exclusionary period. Of those**  
3 **5,314 denials, there were 4,471 claims that PacifiCare reprocessed and owed additional**  
4 **amounts on totaling \$1,012,097. These claims affected at least 2,020 members. In addition,**  
5 **in 2006, there were 843 claims illegally denied on this basis but no additional amount was**  
6 **owed. (CDI does not have data on the number of such claims for 2004, 2005, 2007, or**  
7 **2008.) These subcategories are shown below.**

<b>Subcategory</b>	<b>Number of Acts in Violation</b>
Denied due to application of 12-month period — Money owed	3,645
Denied due to application of 12-month period — No money owed	826
Denied due to improper application of 6-month pre- existing condition policy	843

12  
13                   **First, given this information, were these acts knowingly committed or**  
14 **performed with such frequency as to indicate a general business practice?**

15           A.     Yes. These acts were knowingly committed. PacifiCare had full knowledge of  
16 the true facts, namely whether the claim arose more than six months after the member's  
17 effective date, and is, of course, chargeable with knowledge of the applicable law regarding the  
18 permissible exclusion period. PacifiCare is also chargeable, when adjudicating a claim on the  
19 basis of pre-existing condition exclusion, with knowledge that its files were inadequate to make  
20 such a determination. And, and under the assumed facts I was given, PacifiCare assigned claims  
21 to MedPlans with prior knowledge of the deficiencies in its performance.

22           **Q.     Based on the information you have been given, was the issuance, amendment,**  
23 **or servicing of the policy or endorsement inadvertent, as that term is used in section**  
24 **790.035?**

25           A.     No. The servicing of the policy relevant to the charged acts in violation was  
26 PacifiCare's sending of the claim denials. There is no evidence that PacifiCare inadvertently  
27 sent those claim denials.

1           **Q.     Based on the facts provided, do you classify these pre-existing condition**  
2 **violations as willful or non-willful?**

3           A.     I will consider the 4,417 claims denied due to the improper application of the  
4 twelve-month exclusionary period to be non-willful unfair acts and practices. While I think that  
5 the failure to verify the details of the policy before submission to CDI and before implementing  
6 the twelve-month period in RIMS is negligent, it does not rise to a “purpose or willingness” to  
7 fail to implement reasonable claims-processing standards or to misrepresent pertinent facts.

8           The 826 claims denied due to improper application of the pre-existing condition  
9 provisions after the exclusionary period was corrected represent willful acts and practices.  
10 PacifiCare knew that MedPlans was not meeting quality standards with respect to claims  
11 processing; that pre-existing conditions claims are among the most complicated to adjudicate;  
12 and that the financial arrangement with MedPlans encouraged claim denials rather than careful  
13 adjudication. The evidence therefore shows that as to these 826 claims, PacifiCare purposely or  
14 willingly misrepresented to claimants pertinent facts regarding coverage and failed to implement  
15 reasonable claims-processing standards.

16           **Q.     So your baseline penalty per act in violation of this provision is 65% of**  
17 **\$5,000, or \$3,250, for the 3,645 claims where the denial was due to the application of the**  
18 **twelve-month exclusionary period and where payment was owed to the provider; 65% of**  
19 **\$10,000, or \$6,500 for the 826 claims processed improperly after the six-month period was**  
20 **implemented; and 50% of 5,000, or \$2,500 for the 843 claims where no payment was owed?**

21           A.     Yes.

22           **Q.     Now, in light of the facts you have been asked to assume and the factors**  
23 **enumerated in section 2695.12, what penalty would you propose for this category of alleged**  
24 **violations?**

25           First, I have seen no evidence of the existence of extraordinary circumstances.  
26 (Reg. § 2695.12, subd. (a)(1).) CDI’s authorization of the certificate containing the illegal  
27 exclusionary period was an oversight by the Department, but it does not constitute an  
28 “extraordinary circumstance” as that term is defined by the Regulations. (Reg. § 2695.12,

1 subd. (e).) It was in PacifiCare’s control not to submit to the Department a certificate that  
2 contained an illegal provision in the first instance; it was within PacifiCare’s control to  
3 subsequently detect the illegal provision; it was within PacifiCare’s control to promptly  
4 remediate the illegally denied claims. Nor are there any circumstances that “severely and  
5 materially affect[ed] the licensee’s ability to conduct normal business operations.” (Reg. §  
6 2695.12, subd. (e).)

7 The complexity of adjudicating claims involving pre-existing conditions is a mitigating  
8 factor for some of the incorrectly denied claims at issue. (Reg. § 2695.12, subd. (a)(3).) Claims  
9 involving pre-existing conditions are among the more difficult to process. This consideration  
10 applies to the 826 claims that were incorrectly processed based on the corrected six-month  
11 exclusionary period. But the remaining 4,488 claims were improperly denied because of the  
12 illegal provision in the company’s form policy, which is unrelated to the complexity of the  
13 processing these claims. This is not a mitigating factor for those claims.

14 The relative frequency of the claims affected by this violation is not relevant in this  
15 instance. (Reg. § 2695.12, subd. (a)(7).) PacifiCare identified the affected claims and the  
16 Department did not review claims other than those that contained these violations.

17 PacifiCare undertook remedial measures to update RIMS to properly process claims, to  
18 revise their large group policy, and to reprocess the incorrectly denied claims. (Reg. § 2695.12,  
19 subd. (a)(8).) I also credit the company for undertaking further remedial actions in response to  
20 deficiencies found in the MCE. I note that while PacifiCare refused to suspend the application  
21 of the exclusion period in 2008, it offered to undertake the alternative “grandfathering” policy.  
22 However, it ultimately did not adopt that measure, and it is clear that PacifiCare was incorrectly  
23 denying claims involving pre-existing conditions as late as 2008. I nonetheless view  
24 PacifiCare’s remediation efforts around this issue as a mitigating factor.

25 There is no evidence that PLHIC had committed previous violations of this kind.  
26 (Reg. § 2695.12, subd. (a)(9).) This is a slightly mitigating factor with respect to the violations  
27 resulting from the illegal twelve-month policy that was implemented in 2004. The violations in  
28 2007 and 2008, however, appear to reflect claims processing errors related to the outsourcing to

1 MedPlans after the acquisition. For the reasons stated above, the lack of previous violations is  
2 not relevant to those violations.

3           There is some evidence of harm in addition to that usually seen in violations of this  
4 kind. (Reg. § 2695.12, subd. (a)(10).) Beyond the harm caused by improperly denied claims  
5 where payment was owed, there were some uncharged violations where the claim was  
6 improperly denied but applied to the member's deductible. As I discussed in the context of  
7 COCC-based denials, these violations still harm members even if the provider is not improperly  
8 denied payment. Moreover, the inclusion of the twelve-month exclusionary policy in all large  
9 group policies and certificates of coverage during a two-year period may have harmed other  
10 members who deferred seeking needed medical care for longer than necessary.

11           Under the totality of circumstances, I will credit PacifiCare for making a good faith  
12 attempt to comply as to the claims incorrectly denied based on the illegal twelve-month pre-  
13 existing condition period. (Reg. § 2695.12, subd. (a)(12).) PacifiCare could have implemented  
14 better process controls around drafting its form policies, and insurers are not entitled to rely on  
15 CDI's authorization of a new policy as a certification that that policy is fully compliant.  
16 However, given that CDI staff reviewing PacifiCare's certificate also did not detect the incorrect  
17 exclusionary period, I will not hold it against PacifiCare for failing to detect that illegal  
18 provision. I also credit PacifiCare for self-disclosing the improper policy provision to the  
19 Department and for reworking the affected claims. This mitigation applies to the 4,488 claims  
20 that were denied based on the illegal provision. It does not apply to the 826 claims that  
21 PacifiCare incorrectly denied from October 2006 to March 2008, after the policy provision was  
22 corrected. Those were incorrectly denied because PacifiCare's claims examiners, and MedPlans  
23 examiners, were improperly applying the pre-existing condition. While PacifiCare eventually  
24 implemented weekly audits of these claims, the company's decision to outsource these more  
25 complex claims to a vendor with known performance problems likely resulted in an increased  
26 number of incorrect denials. I do credit PacifiCare for reworking those claims. But overall, I did  
27 not see evidence of a good faith attempt to comply as to those 826 claims.

28

1           Every large group policy issued between 2004 and 2006 contained an illegal pre-  
2 existing conditions exclusionary period, but the policy was not applicable to every claim. There  
3 were over 2,000 members affected, which is a significant number, and these members  
4 experienced a severe detriment to their health, which can have ripple effects in their families and  
5 communities. (Reg. § 2695.12, subd. (a)(12).)

6           It was PacifiCare that ultimately discovered that the large group policy contained an  
7 illegal exclusionary period, which suggests that it had facts available that should have apprised it  
8 of the noncompliance earlier. (Reg. § 2695.12, subd. (a)(13).) Indeed, properly trained claims  
9 examiners should have determined that RIMS was set to apply an illegal exclusionary period to  
10 these policies. I regard this as only a slightly aggravating factor in light of CDI's own failure to  
11 ascertain that the policy was illegal when it was filed. I also view it an aggravating factor that  
12 PacifiCare did not reprocess incorrectly denied claims from 2004 and 2005 until February 2008.  
13 PacifiCare knew at the end of 2006 that it had been using a policy with an illegal exclusionary  
14 period since 2004, yet it waited over a year to reprocess these 2004 and 2005 claims. Affected  
15 claimants thus had to wait three or four years to have their claims correctly processed.

16           On balance, I believe these factors represent mitigating circumstances, as  
17 compared to the generic violation. I therefore think it appropriate to reduce the penalty by 50%  
18 for the violations associated with the application of the illegal twelve-month exclusionary period,  
19 from \$3,250 to \$1,625 for the 3,645 claims where payment was owed to a provider, and from  
20 \$2,500 to \$1,250 for the 843 claims where no payment was owed. As to the 826 claims that  
21 were wrongly denied based on the incorrect application of the six-month exclusionary period, I  
22 think it appropriate to decrease the penalty by 10%, from \$6,500 to \$5,850. Therefore, my  
23 aggregate recommended penalty for this violation is \$11,808,975.

1           **C.     PacifiCare’s Failure to Give Notice to Providers of Their Right to**  
2           **Appeal to CDI**

3           **Q.     Are you aware of the allegations that PacifiCare failed to provide on its**  
4           **Explanations of Payment (EOP) notice to providers of their right to appeal to CDI in**  
5           **violation of law?**

6           A.     Yes.

7           **Q.     Do EOP notices that omit notice of providers’ right to appeal to CDI, and**  
8           **contact information for CDI appeals, violate sections of the Insurance Code or the Fair**  
9           **Claims Settlement Practices Regulations?**

10          A.     Yes. Insurance Code sections 10123.13, subdivision (a), and 10123.147,  
11          subdivision (a), specifically require inclusion of a notice that providers may seek review by the  
12          Department of any claim that is contested or denied, and that the notice must include contact  
13          information for the Department. Section 2695.7, subdivision (b), of the Fair Claims Settlement  
14          Practices Regulations also specifies that all written communications accepting or denying claims  
15          must include this information. Omission of this information is a violation of Insurance Code  
16          section 790.03, subdivision (h)(1), because the right to appeal to CDI is a pertinent fact, and  
17          omission of the notice is a misrepresentation of both the provider’s right to payment and the  
18          insured’s rights related to coverage. Finally, deficient EOPs are violations of section 790.03,  
19          subdivision (h)(3), because they reflect failures to adopt and implement reasonable standards for  
20          prompt investigation and processing of claims arising under insurance policies.

21          **Q.     PacifiCare contends that the failure to include the notice on EOPs is not a**  
22          **misrepresentation under section 790.03(h)(1), because only affirmative misstatements**  
23          **constitute misrepresentations, and because the existence of a right to appeal is not a**  
24          **“pertinent fact” under that section. Do you agree?**

25          A.     I do not agree. When an insurer is legally obligated to communicate a fact and  
26          omits that fact, CDI regards that as a misrepresentation. Otherwise, insurers could omit any  
27          information from communications with claimants that they prefer claimants not know, and that  
28          would be inconsistent with the legislative scheme requiring fair claims practices. In fact, the  
29          Regulations define the “single act” for the purpose of determining any penalty pursuant to

1 section 790.035 as “any commission or *omission* which in and of itself constitutes a violation of  
2 California Insurance Code Section 790.03 or this subchapter.” (Reg. § 2695.2, subd. (v)  
3 (emphasis added).) Moreover, EOPs that purport to provide information about providers’ right  
4 to appeal, but only advise providers that they may appeal to the insurance company,  
5 affirmatively misstate the extent of providers’ appeal rights. The Department regards legal  
6 rights that can affect recovery as “pertinent,” and the right to appeal to a state agency tasked  
7 with enforcing their rights certainly affects providers’ ability to recover amounts owed to them.

8 **Q. In general, how would you rate the severity of a company’s failure to include**  
9 **in an EOP a notice of the provider’s right to appeal a contested or denied claim to the**  
10 **Department?**

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

15 The prompt and accurate payment of claims is, of course, critical to the provider,  
16 the patient, the insurer, and the healthcare system. The notice prescribed in Insurance Code  
17 section 10123.13 is an important part of the system the Legislature has established for resolution  
18 of disputes about claim processing.

19 I also believe that the right to Department review should be viewed as an  
20 opportunity to petition government and that this violation represents the denial of a mandatory  
21 notice to inform affected persons of that right. So beyond value the notice may have in  
22 correcting improper practices by the insurer, the absence of the required notice should be  
23 recognized as denying some people the knowledge of their right to petition their government,  
24 which I view as serious.

25 **Q. Do you attach any significance, for penalty purposes, to the fact that the**  
26 **same information may have been provided in the certificate of insurance and other**  
27 **documents?**

1           A.     Not much. If the company had also failed to provide the notice in other  
2 documents the provider receives, that would be an aggravating factor and would be cited as  
3 independent acts in violation. But providers are unlikely to see and fully absorb the information  
4 in a single exposure. The fact that the Legislature has required the notice to appear in multiple  
5 documents confirms that the Legislature was aware that multiple notifications were required,  
6 and confirms that giving the notice once does not meet the insurer's obligations. Further, since  
7 providers do not typically receive the certificate of insurance and other documents provided to  
8 the policyholder, the EOP may be the only and most valuable and important place for the  
9 provider to receive the notice, since it occurs at the time when the potential need for CDI review  
10 is greatest, when the provider has just received a denied or contested claim.

11           **Q.     Must insurers include the notice of providers' right to appeal on all EOPs, or**  
12 **only those issued when PacifiCare denies or contests a claim?**

13           A.     Virtually all EOPs require notice of the right to appeal to the Department.

14           **Q.     Even if the insurer pays the claim?**

15           A.     Yes, unless the insurer pays it exactly as billed. Section 2695.7, subdivision (b),  
16 requires the insurer to accept or deny each claim and document the amounts accepted and denied.  
17 An amount that lists some part of the claim as "allowed" and some part as "not allowed" is  
18 accepting part of the claim but denying the rest. The provider can appeal to the Department even  
19 if the claim was only partly denied. So the only instance in which no part of the claim is denied  
20 is if the insurer actually pays the full billed amount, which in my experience is almost never. I  
21 would be prepared to deduct such EOPs from the number of charged violations, but I have seen  
22 no evidence that any of the EOPs issued in this case were for amounts exactly matching the  
23 billed amount.

24           **Q.     But if the claim is paid at the contractually agreed rate, would there be any**  
25 **reason for the provider to appeal to the Department?**

26           A.     Yes. For example, if the EOP stated that the provider was being reimbursed at the  
27 contracted rate but the insurer applied the wrong rate, the provider would need to be informed of  
28

1 his or her right to appeal to the Department. Likewise, if one claim line is paid but another claim  
2 line is denied, appeal rights are relevant.

3 **Q. Taking all these things into account, where do you place this type of violation**  
4 **on the section 790.035 spectrum from zero to either \$5,000 or \$10,000 per act in violation?**

5 A. Consistent with my earlier description of this violation as moderately serious, I  
6 would put it at 30% of the way from zero to the maximum, or \$1,500 for a non-willful act in  
7 violation and \$3,000 for a willful act in violation.

8 **Q. Now, let me describe for you the background on these particular EOP**  
9 **violations. Please assume the following facts:**

10 **As you are aware, section 10123.13, subdivision (a), which requires that**  
11 **insurers provide for any contested or denied claims notice of the provider's or insured's**  
12 **right to seek review by CDI and of CDI's address and other contact information, became**  
13 **effective on January 1, 2006. Until June 15, 2007, however, PacifiCare's EOPs informed**  
14 **providers of their right to submit a provider dispute to PacifiCare, but failed to inform**  
15 **them of their right to appeal to CDI, and failed to notify them how to contact CDI.**

16 **PacifiCare admits that until June 15, 2007, its EOPs for group PPO claims**  
17 **failed to include this statutorily required language. PacifiCare's Regulatory Compliance**  
18 **Log, generated around December 2005, noted that section 10123.13, subdivision (a),**  
19 **required "Notice to provider and insured shall advise them that either may seek review by**  
20 **the Dept. of Insurance of a claim that the insurer contested or denied." PacifiCare**  
21 **maintains that it erroneously interpreted section 10123.13, subdivision (a), as requiring**  
22 **only notice of the "plan's internal provider dispute mechanism." Ms. Monk testified that**  
23 **the incorrect interpretation was "understandable" because the word "department" in**  
24 **section 10123.13, subdivision (a), is not capitalized, and could therefore refer to the**  
25 **department within the insurance company that reviews provider disputes rather than the**  
26 **Department of Insurance. She also testified that PacifiCare has since improved its**  
27 **procedures for tracking and implementing new statutory and regulatory requirements.**

1           **CDI informed PacifiCare on February 22, 2007, that the company’s EOP**  
2 **forms sent to providers did not include the required notice of the right to appeal to the**  
3 **Department of Insurance. On March 23, 2007, PacifiCare sent CDI a new EOP template**  
4 **that included the right to appeal to CDI as well as the Department’s contact information.**  
5 **PacifiCare represented that the new language was “in progress and will be included on**  
6 **[EOPs] as of 4/8/07.” A month later, on April 27, 2007, PacifiCare forwarded to CDI a**  
7 **revised version of the EOP form that included the statutorily required language regarding**  
8 **the right to appeal to the Department, but did not implement the revised EOP for group**  
9 **PPO claims until June 15, 2007, and did not implement the revised EOP for individual**  
10 **PPO claims until November 4, 2007. From the time that CDI informed PacifiCare that its**  
11 **EOPs were deficient, on February 22, 2007, until June 15, 2007, PacifiCare issued at least**  
12 **462,805 illegal EOPs. CDI does not have sufficient data to determine the number of**  
13 **deficient EOPs for individual claims that PacifiCare issued from June 1, 2007, to**  
14 **November 4, 2007.**

15           **PacifiCare contends it failed to implement compliant EOPs sooner because it**  
16 **was waiting for CDI to “approve” the revised language for EOBs advising insureds of their**  
17 **right to seek an Independent Medical Review. According to PacifiCare, “the EOB and**  
18 **EOP changes were being handled as a single corrective action project by the Regulatory**  
19 **team. Because they were modifying claim documents associated with the same scope and**  
20 **population of claims on the same claim platform ... they were handling it as a single**  
21 **project.” PacifiCare has acknowledged that there was no requirement that the EOP and**  
22 **EOB revisions be treated as a “single project” and that the company “could have**  
23 **implemented this earlier than we did the IMR language.” Rather, PacifiCare asserts only**  
24 **that it was “trying to manage the project effectively and to minimize the number of times**  
25 **that the team would have to touch the system.” PacifiCare contends that CDI understood**  
26 **PacifiCare was treating EOPs and EOBs as a single project, and that CDI delayed**  
27 **implementation of compliant EOB language and therefore was also indirectly responsible**  
28 **for PacifiCare’s delay in implementing compliant EOP language.**

1                   PacifiCare further contends that no harm resulted from the omission of the  
2 notices, because providers were aware of their right to appeal from other sources, and that  
3 the lack of harm is proven by the fact that justified complaints did not rise by a statistically  
4 significant amount following the issuance of compliant EOPs. The evidence, however, does  
5 demonstrate that provider complaints did in fact rise, and in fact the justified complaint  
6 rate increased by 10% following the inclusion of the right-to-CDI-review language on  
7 PacifiCare’s EOPs — and did so at a time, in the second half of 2007, when PacifiCare  
8 claims its corrective actions were taking hold. Aileen Wetzel of the California Medical  
9 Association (CMA) testified that even for providers who were aware of the right to appeal  
10 contested and denied claims, the omission of the notice meant that providers did not know  
11 whether to appeal to CDI or DMHC, since the insureds’ status was not otherwise listed.  
12 During the period of noncompliance, providers also reported that PacifiCare was  
13 unresponsive when contacted about underpayments and improper claims denials.

14                   **First, given this information, were these acts knowingly committed or**  
15 **performed with such frequency as to indicate a general business practice?**

16                   A.     Yes, these are acts in violation that PacifiCare knowingly committed. PacifiCare  
17 had actual knowledge at least as of February 22, 2007, when the Department notified the  
18 company that its EOPs were illegally omitting the CDI-review notification language. Thus,  
19 PacifiCare knew as of that date that all EOPs being sent were misrepresenting pertinent facts,  
20 and it knew that as of that date it had not implemented reasonable standards for claims  
21 processing because it was failing to include this notice in outgoing EOPs.

22                   **Q.     Based on the information you have been given, was the issuance, amendment,**  
23 **or servicing of the policy or endorsement inadvertent, as that term is used in section**  
24 **790.035?**

25                   A.     No, not at all. I have seen no evidence to refute my understanding that PacifiCare  
26 intended to service the policies by mailing each of those EOPs.

27                   **Q.     Given this background, do you classify the EOP violations as willful or non-**  
28 **willful?**

1           A.       These violations are both willful and in knowing violation of law. There is  
2 evidence that PacifiCare knew when SB 367 was enacted that providers' right to appeal to the  
3 Department of Insurance must be included in notices of dispute resolution mechanisms and  
4 failed to do so. However, CDI is charging as violations only those deficient EOPs that  
5 PacifiCare issued after the Department brought the omission of the notice to PacifiCare's  
6 attention. As to these violations, PacifiCare exhibited a willingness to misrepresent the  
7 existence and nature of appeal rights, and a willingness to not implement reasonable standards  
8 for claims processing by including the notice in outgoing EOPs as soon as practicable. Further,  
9 under Regulation 2695.2, subdivision (y), PacifiCare need not have viewed an EOP without full  
10 provider rights as an act punishable by section 790.03, subdivisions (h)(1) or (h)(3), because no  
11 intent to violate the law is required. It must merely have purposely or willingly disseminated  
12 EOBs that omitted an accurate description of the procedures available to providers for disputing  
13 those EOBs. The facts I have been asked to assume describe such a circumstance.

14           **Q.       Is it reasonable to assume that PacifiCare could have revised and begun**  
15 **disseminating legally compliant EOPs the day after CDI called the violations to its**  
16 **attention?**

17           A.       There might theoretically be a brief lag for an insurer to implement compliant  
18 language on a form letter, during which time the Department might not consider such violations  
19 willful. I would be surprised if it took an insurer more than a few days to implement changes to  
20 form communications, especially where it had access to compliant language. In this case  
21 PacifiCare has not contended that the delay was due to operational obstacles. However, in this  
22 case, even if the EOPs sent during the first few days after PacifiCare was notified that it was out  
23 of compliance are considered non-willful, it would not affect the total penalty. As I explain  
24 below, the approach I used to calculate an aggregate penalty for this category includes a very  
25 small per-violation penalty for hundreds of thousands of violations, even less than the amount I  
26 would have assigned had I regarded many of the violations as non-willful.

27           **Q.       So your baseline penalty per act in violation of this provision is 30% of**  
28 **\$10,000, or \$3,000?**

1 A. Yes.

2 **Q. Now, in light of the facts you have been asked to assume and the factors**  
3 **enumerated in section 2695.12, what penalty would you propose for this category of alleged**  
4 **violations?**

5 First, I have seen no evidence of the existence of extraordinary circumstances (Reg.  
6 § 2695.12, subd. (a)(1)), which is defined by the Regulations to mean “circumstances outside of  
7 the control of the licensee which severely and materially affect the licensee’s ability to conduct  
8 normal business operations” (Reg. § 2695.12, subd. (e)).

9 There was also no evidence that these violations were related to the complexity of  
10 the underlying claims. (Reg. § 2695.12, subd. (a)(3).)

11 The fact that every single EOP for group claims issued during the period of  
12 February 22, 2007, and June 15, 2007, and every EOP for individual claims issued from  
13 February 22, 2007, and November 4, 2007, were noncompliant is an aggravating factor. (Reg. §  
14 2695.12, subd. (a)(7).)

15 There is some evidence of remedial measures. PacifiCare eventually fixed their  
16 EOP format to include the required notice, and the company contends that it has enhanced the  
17 regulatory review process to achieve better compliance with new laws in the future. (Reg. §  
18 2695.12, subd. (a)(8).) However, I also took into consideration the fact that PacifiCare took  
19 almost four months to begin issuing compliant EOPs for group claims and over eight months to  
20 begin issuing compliant EOPs for individual claims. PacifiCare has articulated no acceptable  
21 basis to delay compliance for that long after having been informed of its noncompliance.

22 I also considered the existence of previous violations of this kind. (Reg. § 2695.12,  
23 subd. (a)(9).) There were hundreds of thousands of noncompliant EOPs issued before February  
24 21, 2007. Therefore, even though these previous violations have not been charged, I see this as a  
25 slight aggravating factor.

26 There is evidence that these violations caused more harm than is usual with  
27 violations of this kind. (Reg. § 2695.12, subd. (a)(10).) Assuming that PacifiCare did not  
28 indicate on its EOPs the type of health care plan under which the insured was covered, the

1 provider would not have known which regulator had jurisdiction over a contested or denied  
2 claim absent the notice. The fact that complaints rose following the inclusion of the notice  
3 suggests that providers took advantage of the new information. There is also the underlying  
4 harm of claims violations that could have been remedied, or remedied more quickly, if the  
5 provider had known to bring the claims to the Department's attention. There is evidence that  
6 PacifiCare's processes for dealing with telephone inquiries and addressing written provider  
7 complaints were wholly inadequate during the MCE period, thus making the need for  
8 Department intervention more acute. Finally, in the context of PacifiCare's operations with an  
9 unusually high rate of violations during this period, it follows that compliant EOPs were  
10 especially important for the company at this time.

11 Under the totality of circumstances, I do not believe PacifiCare exhibited a good  
12 faith attempt to comply with these Regulations. (Reg. § 2695.12, subd. (a)(12).) It is difficult to  
13 credit PacifiCare's belief that the law required notice only of providers' rights to utilize  
14 PacifiCare's internal dispute resolution mechanism when their own compliance log recognized  
15 the requirement to notify providers of the right to CDI appeal. In addition, Insurance Code  
16 section 21 defines "department" with a lowercase "d" as the "Department of Insurance of this  
17 state." Therefore, I see no reasonable basis to conclude that "department" as used in  
18 section 10123.13, subdivision (a), meant anything other than the Department of Insurance.  
19 Regulation section 2695.7, subdivision (b), further requires that:

20 "(3) Written notification pursuant to this subsection shall include a  
21 statement that, if the claimant believes all or part of the claim has been  
22 wrongfully denied or rejected, he or she may have the matter reviewed by  
23 the California Department of Insurance, and shall include the address and  
telephone number of the unit of the Department which reviews claims  
practices."

24 This regulation has been in effect since around 1991, and pertains to denials issued to providers,  
25 who are "claimants," as defined by these same regulations. This subsection (b)(3) clearly  
26 identifies the department as the California Department of Insurance. Moreover, the Department  
27 has only charged violations that occurred after CDI informed PacifiCare that its EOPs were  
28 deficient. If PacifiCare had been attempting in good faith to comply with the law, it would

1 have revised the provider rights section of its EOP immediately after CDI notified it of  
2 noncompliance, not months later.

3 Since every EOP was noncompliant, this violation involves a relatively high  
4 frequency of violations. (Reg. § 2695.12, subd. (a)(12).) The severity of detriment to the public  
5 as a whole of these violations, as distinguished from the generic violation, is difficult to  
6 calculate, because it is impossible to know how many PacifiCare providers were unaware of  
7 these rights, how many providers would have taken advantage of their right to complain, or how  
8 many would have felt comforted by knowledge of that right even if they did not immediately  
9 exercise it. Nevertheless, I will conservatively assume that the detriment to the public was not  
10 more severe than in the generic violation.

11 The fact that PacifiCare was aware of its noncompliant EOPs in February 2007, at  
12 the latest, and did not begin issuing legally sufficient EOPs until June 2007 for group claims and  
13 November 2007 for individual claims, is an aggravating factor. Moreover, PacifiCare had  
14 information on its compliance log that should have triggered it to issue compliant EOPs far  
15 earlier. (Reg. § 2695.12, subd. (a)(13).)

16 On balance, I believe these factors represent a set of circumstances that are  
17 slightly aggravating, as compared to the generic violation of the EOP notice requirement. I  
18 therefore think it appropriate to increase the penalty by 10%, from \$3,000 to \$3,300 per act in  
19 violation.

20 **Q. So that results in 462,805 acts in violation of the law at \$3,300 per act. Are**  
21 **there any other adjustments you think are appropriate?**

22 A. Yes. This category, because it contains hundreds of thousands of acts in  
23 violation, introduces a new issue. Ordinarily we assume each violation is of equal gravity so we  
24 simply pick a single per-violation penalty and multiply that by the number of acts in violation to  
25 identify a reasonable penalty for the entire category, and that approach normally yields  
26 appropriate penalties. However, it is not necessarily the case that every act in violation is of  
27 equal severity and needs to be given the same penalty, and that is not the case here.

1 To illustrate, if this case had come to me with just a single EOP in violation and all of the  
2 other factors the same, I would have no hesitation in saying that the company should be  
3 penalized \$3,300 for that single act, and I would view a reduction from that amount as  
4 inappropriate. However, I do not view it necessary to penalize the 400,000th identical act as  
5 severely as the first. Each act in violation should be punished, and where victims have been  
6 harmed the punishment for each act should exceed that harm. In addition, each act should be  
7 punished in an amount greater than any benefit the company may have realized from committing  
8 that act, and the aggregate penalty for the category should be sufficient to deter such violations  
9 in the future. Furthermore, no act in violation should receive a penalty less than a minimum that  
10 recognizes the systemic harm from violating the law.

11 I have reflected on how to take this consideration into account and have settled on a fairly  
12 simple rule: After 50,000 violations, I would reduce the per-act penalty by 50%, and I would  
13 continue to reduce the penalty by 50% after each additional 50,000 violations. Finally, I would  
14 not allow the per-act penalty to fall below \$50, which minimally recognizes that each additional  
15 act is an affront to the law. The following table reflects this calculation.

16  
17

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

18  
19  
20  
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23  
24

25 In the case of PLHIC's EOP violations, this approach produces an aggregate penalty of  
26  $50,000 \times \$3,300 + 50,000 \times \$1,650 + 50,000 \times \$825 + 50,000 \times \$412 + 50,000 \times \$206 + 50,000$   
27  $\times \$103 + 50,000 \times \$51 + 112,805 \times \$50$ , which equals \$332,990,250. One of the  
28

1 virtues of this approach in this case is that it accommodates the possibility that some of  
2 the violations — those issued just after the Department notified PacifiCare that their EOPs were  
3 noncompliant — could be considered non-willful. I have assigned a very small penalty for over  
4 150,000 of the violations, which is far more than the number of EOPs than would be issued  
5 during a reasonable implementation period of a few days. On average, this aggregate value  
6 represents a penalty of approximately \$720 per act in violation. Again, that is a penalty that I  
7 would view as too low were there merely a single or several violations, but I think it is a  
8 reasonable average over the entire 462,805 violations. Therefore, my recommended aggregate  
9 penalty for this category is \$332,990,250.

10 **D. PacifiCare’s Failure to Provide Notice to Insureds of Their Right to**  
11 **Request an Independent Medical Review**

12 **Q. Are you aware of the allegations that PacifiCare failed to include notice to**  
13 **members of their right to seek an Independent Medical Review (IMR) on the “Know Your**  
14 **Rights” page of its Explanations of Benefits (EOB) in violation of law?**

15 A. Yes.

16 **Q. Do EOB notices that omit notice of members’ right to request an IMR violate**  
17 **sections of the Insurance Code or the Fair Claims Settlement Practices Regulations?**

18 A. Yes. Insurance Code section 10169, subdivision (i), specifically requires insurers  
19 to “prominently display” information about IMR rights “in every insurer member handbook or  
20 relevant informational brochure, in every insurance contract, on insured evidence of coverage  
21 forms, on copies of insurer procedures for resolving grievances, on letters of denial issued by  
22 either the insurer or its contracting organization, and on all written responses to grievances.” An  
23 EOB constitutes a “notice of denial” whenever the billed amount is not paid in full. The “Know  
24 Your Rights” page is also a “copy of insurer procedures for resolving grievances.” The failure  
25 to include the IMR information therefore violates section 10169. Section 2695.4, subdivision  
26 (a), of the Fair Claims Settlement Practices Regulations also requires the insurer to disclose “all  
27 benefits, coverage, time limits or other provisions of any insurance policy” that may apply to the  
28 claim. Omission of this information is a violation of Insurance Code section 790.03, subdivision

1 (h)(1), because the right to obtain an IMR is a pertinent fact, and an EOB that fails to provide  
2 notice of that right misrepresents the insured's rights related to coverage. Finally, such deficient  
3 EOBs are violations of section 790.03, subdivision (h)(3), because they reflect failures to adopt  
4 and implement reasonable standards for prompt investigation and processing of claims arising  
5 under insurance policies.

6 **Q. PacifiCare contends that the failure to include the notice on EOBs is not a**  
7 **misrepresentation under section 790.03, subdivision (h)(1), because only affirmative**  
8 **misstatements constitute misrepresentations, and because the existence of a right to appeal**  
9 **is not a “pertinent fact” under that section. How does the Department interpret this**  
10 **provision with respect to EOBs?**

11 A. As previously noted, when an insurer is legally obligated to communicate a fact  
12 and omits that fact, CDI regards that as a misrepresentation. Otherwise, insurers could omit any  
13 information from communications with claimants that they prefer claimants not to know, and  
14 that would be inconsistent with the legislative scheme requiring fair claims practices. As also  
15 noted, the Regulations define the “single act” for the purpose of determining any penalty  
16 pursuant to section 790.035 as “any commission or omission which in and of itself constitutes a  
17 violation of California Insurance Code Section 790.03 or this subchapter.” (Reg. § 2695.2,  
18 subd. (v).) Moreover, an EOB that purports to provide information about members' right to  
19 appeal adverse decisions will be interpreted to include all avenues of redress available to the  
20 member. If it does not include notice of the right to seek an independent review, the consumer  
21 will reasonably conclude that no such right exists. Such EOBs therefore affirmatively  
22 misrepresent the scope of insureds' rights. The right to seek review of a coverage decision by an  
23 independent medical board is one that can affect coverage and benefits available under the  
24 insurance policy, and is therefore a “pertinent fact.”

25 **Q. Must insurers include the notice of consumers' right to an IMR on all EOBs,**  
26 **even if the claim is contested or denied for reasons other than medical necessity?**

27 A. Yes. The statute requires inclusion of IMR information on all “letters of denials  
28 issued by [] the insurer” without limitation. The notice must also appear on “copies of insurer

1 procedures for resolving grievances.” (Ins. Code, § 10169, subd. (i).) An insurer that includes a  
2 recitation of appeal procedures in each EOB is therefore obligated to include the IMR rights.

3 **Q. In general, how would you rate the severity of a company’s failure to include**  
4 **in an EOB or “Know Your Rights” page information on members’ right to an IMR?**

5 A. In comparison to the range of violations to which section 790.035 applies, I view  
6 the EOP-notice violation as moderately serious. I view the failure to provide notice of IMR  
7 rights as slightly more serious than the omission of providers’ rights to appeal to the  
8 Department, because in my experience consumers are less aware of their rights than providers.  
9 This omission is therefore more harmful.

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

19 The right to seek an IMR involves the right to petition government. This violation  
20 represents the denial of a mandatory notice to inform affected persons of that right. So beyond  
21 the value the notice may have in correcting improper practices by the insurer, the absence of the  
22 required notice should be recognized as denying some people the knowledge of their right to  
23 petition their government, which I view as serious.

24 **Q. Taking all these things into account, where do you place this type of violation**  
25 **on the section 790.035 spectrum from zero to either \$5,000 or \$10,000 per act in violation?**

26 A. Consistent with my earlier description of this violation as moderately serious, I  
27 would put it at 35% of the way from zero to the maximum, or \$1,750 for a non-willful act in  
28 violation and \$3,500 for a willful act in violation.

1           **Q.     Now, let me describe for you the background on these particular EOB**  
2 **violations. Please assume the following facts:**

3                   **As you are aware, Section 10169, subdivision (i), requires:**

4                   **“No later than January 1, 2001, every disability insurer shall**  
5 **prominently display in every insurance member handbook or relevant**  
6 **informational brochure, in every insurance contract, on insured**  
7 **evidence of coverage forms, on copies of insurer procedures for**  
8 **resolving grievances, on letters of denials issued by either the insurer**  
9 **or its contracting organization, and on all written responses to**  
10 **grievances, information concerning the right of an insured to request**  
11 **an independent medical review in cases where the insured believes that**  
12 **health care services have been improperly denied, modified, or**  
13 **delayed by the insurer, or by one of its contracting providers.”**

14 **At least as early as 2006, the “Know Your Rights” page of PacifiCare’s EOBs for group**  
15 **claims informed consumers of their right to appeal adverse decisions to PacifiCare,**  
16 **mentioned dispute resolution rights under ERISA, and stated that “the Department of**  
17 **Insurance can assist with questions about the health care appeals process or if the Insured**  
18 **believes that there has been a violation of the state unfair practices ... laws.”**

19                   **But until June 15, 2007, these group claim EOBs failed to include language**  
20 **notifying insureds of their right to request an IMR. Individual claim EOBs failed to**  
21 **include this language until November 4, 2007. PacifiCare admits that its EOBs did not**  
22 **have this IMR language during those periods, but contends that the law does not require**  
23 **such language on EOBs. The company does, however, include IMR notification language**  
24 **on its certificates of coverage, appeal resolution letters, and denial letters for services**  
25 **requested through the pre-authorization process. Ms. Monk testified that PacifiCare**  
26 **believed it was required to notify members of IMR rights only at the point that a member**  
27 **became eligible to obtain an IMR: when PacifiCare had denied a claim as medically**  
28 **unnecessary and the member had already filed an appeal with PacifiCare that had not been**  
29 **resolved. Ms. Monk testified that inclusion of the IMR notice on an EOB in which a claim**  
30 **was not denied as medically unnecessary was “potentially confusing.” Although PacifiCare**  
31 **did not view EOBs as included within the statutory term “letter of denial,” Ms. Monk**

1 agreed that if the term is so defined, then EOBs would require IMR notices going back to  
2 the effective date of section 10169.

3 The Department informed PacifiCare on March 23, 2007, at the latest, that  
4 the company's EOBs unlawfully omitted IMR notification language. During a telephone  
5 conference on that date, PacifiCare requested that CDI provide a sample of language that  
6 would satisfy the statute. CDI responded in writing on March 27, 2007, that it was  
7 PacifiCare's "responsibility to compose IMR language that complies with California law"  
8 but included a sample paragraph that PacifiCare could use, as well as copies of  
9 PacifiCare's own IMR application form and portions of its certificate of coverage, both- of  
10 which included IMR compliant language. CDI's March 27 letter also warned PacifiCare  
11 that "[f]ailure to provide the insureds with their legal rights is a violation of 10169 and  
12 could have had a chilling effect on the filing of IMR applications by the insureds currently  
13 and in the past."

14 Rather than using any of these options offered in that March 27 letter,  
15 PacifiCare chose to draft new IMR language for its EOBs. PacifiCare later explained that  
16 it wanted to add IMR language to its EOBs that would allow it to keep the Know Your  
17 Rights information on a single page.

18 On April 20, 2007, PacifiCare informed CDI it had developed a draft IMR  
19 disclosure and was prepared to implement it on April 30. PacifiCare's new EOB referred  
20 to IMR but failed to explain the circumstances under which it could be requested and  
21 failed to identify with whom insureds are to file a request for an IMR. Nicoleta Smith  
22 informed PacifiCare that this new language did not comply with the law on the same day  
23 that it was received, and stated that she would provide additional feedback the following  
24 week. A week later, having received more comments from CDI, PacifiCare responded that  
25 it had revised the language and was prepared to implement revised EOBs on May 2, but  
26 understood CDI to have additional revisions: "Therefore, the new EOB changes will be  
27 made once we have an opportunity to discuss the new IMR language changes to be made."  
28 PacifiCare sent a new draft EOB to CDI on May 8. CDI immediately advised the company

1 that the new draft was not legally compliant, because it failed to inform consumers that  
2 they would forfeit their right to keep medical information private by requesting an IMR;  
3 referred only to “proposed” medical treatments; and did not make clear that consumers  
4 could obtain an IMR at no cost. CDI urged the company to refer to their existing versions  
5 of compliant IMR language “to facilitate a quicker and more compliant version of the  
6 required notice. Corrective action must be a priority and accomplished expeditiously.”

7 On May 11, PacifiCare sent a paragraph of IMR language (inserted into the  
8 text of an email rather than in an attached EOB). Ms. Smith reviewed the language the  
9 same day and informed PacifiCare that it appeared to be compliant. Ms. Smith testified  
10 that in retrospect, her initial assessment of the draft language was incorrect; it stated that  
11 an IMR could be requested within six months of denial of the disputed service, while under  
12 the law the six-month limitation may be waived at CDI’s discretion.

13 On May 15, PacifiCare sent CDI a copy of the full draft EOB containing the  
14 revised language. While two of Ms. Smith’s colleagues internally agreed at the time that  
15 the EOB appeared compliant, another, Janelle Roy, pointed out several deficiencies in the  
16 document, including the reference to the six-month statute of limitations. Moreover,  
17 PacifiCare failed to inform insureds that requests for IMR are to be filed with CDI, and in  
18 fact placed the IMR language in the same paragraph that discussed rights available under  
19 ERISA and enforced by the Department of Labor. This, Ms. Roy testified, rendered the  
20 IMR language misleading. On May 17, PacifiCare inquired about the status of the draft  
21 IMR, stating that the company’s “systems people are awaiting the go ahead to implement.”  
22 The following day, Ms. Roy circulated to her colleagues a version of PacifiCare’s EOB that  
23 she had revised to include compliant IMR language. CDI made further suggestions to  
24 PacifiCare based on this revised language. Ms. Smith testified that while the Department  
25 does not ordinarily provide proposed language to insurers, it did so in this case in order to  
26 expedite compliance while accommodating PacifiCare’s insistence on a single “Know Your  
27 Rights” page. PacifiCare submitted additional drafts on May 23, and May 29. According  
28 to PacifiCare, CDI received the final version of the EOB on June 1 and communicated to

1 **PacifiCare that its EOBs were compliant on June 4. PacifiCare began disseminating the**  
2 **revised EOBs on June 15, 2007 for group claims, and November 4, 2007, for individual**  
3 **claims. Between March 24 and June 15, 2007, PacifiCare issued at least 336,267 illegal**  
4 **EOBs. CDI does not have sufficient data to determine the number of deficient individual**  
5 **claim EOBs PacifiCare issued from June 1, 2007, to November 4, 2007.**

6 **PacifiCare contends that it had no notice of its obligation to include IMR**  
7 **information on EOBs, because CDI never promulgated a regulation or issued a bulletin**  
8 **notifying insurers that it interpreted section 10169 to require the notice on EOBs.**

9 **PacifiCare also contends that it cannot be faulted for coming up with IMR language that**  
10 **CDI concluded was noncompliant in light of internal CDI emails showing that some CDI**  
11 **officers, who Ms. Smith agreed were “experts” on IMR issues, believed the proposed**  
12 **language to be acceptable.**

13 **PacifiCare also argues that it was prepared to implement new IMR language**  
14 **on April 30, which it contends is a reasonable time after CDI notified the company that the**  
15 **notice must appear on EOBs, and that the only reason revised EOBs were not promptly**  
16 **implemented was CDI’s continued insistence on revisions to the proposed language.**

17 **PacifiCare contends that CDI was aware the company was awaiting “approval” before**  
18 **implementing proposed revisions. Ms. Smith testified, however, that she informed**  
19 **PacifiCare from the beginning that it was the company’s responsibility to implement**  
20 **compliant language immediately; that CDI does not “approve” disclosure language but**  
21 **would, as a courtesy, review PacifiCare’s proposed language and provide feedback; and**  
22 **that she believed that PacifiCare had been implementing revised EOBs based on each of**  
23 **the drafts the company was sending CDI, as an interim measure before arriving at a one-**  
24 **page, legally compliant “Know Your Rights” page. She testified that if PacifiCare had**  
25 **done so, she would have considered them in compliance with the law during that period.**

26 **PacifiCare further contends that no harm resulted from the omission of the**  
27 **notices, because only 57 claims were denied or contested on the basis of medical necessity**  
28 **between March 27 and June 15, 2007. According to PacifiCare, most claims that are**

1 **denied on that basis are resolved without an IMR, because the insured submits additional**  
2 **information in connection with an appeal to PacifiCare. As evidence that consumers were**  
3 **not harmed by the omission of the IMR notice in EOBs, PacifiCare points out that there**  
4 **was no increase in IMR requests following the inclusion of the notice.**

5 **First, given this information, were these acts knowingly committed or**  
6 **performed with such frequency as to indicate a general business practice?**

7 A. Yes, these are acts in violation that PacifiCare knowingly committed. PacifiCare  
8 had actual knowledge at least as of March 23, 2007, when the Department notified the company  
9 that its EOBs were illegally omitting the IMR notification language. Thus, PacifiCare knew as  
10 of that date that all EOBs being sent were misrepresenting pertinent facts, and it knew that as of  
11 that date it had not implemented reasonable standards for claims processing because it was  
12 failing to include this notice in outgoing EOBs.

13 **Q. Based on the information you have been given, was the issuance, amendment,**  
14 **or servicing of the policy or endorsement inadvertent, as that term is used in section**  
15 **790.035?**

16 A. No, not at all. I have seen no evidence to refute my understanding that PacifiCare  
17 intended to service the policies by mailing each of those EOBs.

18 **Q. Given this information, and considering the communications between CDI**  
19 **and PacifiCare regarding the draft IMR language, do you classify the EOP violations as**  
20 **willful or non-willful?**

21 A. These are willful violations. Although the law provides ample notice that IMR  
22 notices must be included on EOBs, CDI is charging as violations only those deficient EOBs that  
23 PacifiCare issued after the Department reminded PacifiCare of the company's obligation to  
24 include the notice. From that point forward, PacifiCare willingly and purposely misrepresented  
25 consumer's rights to appeal, and failed to implement a reasonable EOB as soon as practicable.

26 The Department provided PacifiCare with three examples of compliant language just  
27 days after the initial conversation regarding EOBs, including two that PacifiCare was already  
28 using on other documents. PacifiCare was, of course, entitled to develop alternative legally

1 compliant language, but it was not entitled to continue to omit the IMR notice from its EOBs  
2 while it was doing so. PacifiCare deliberately chose to continue issuing EOBs that it knew  
3 misrepresented consumers' rights.

4 **Q. Even if PacifiCare's misrepresentations were willful, is it unfair to hold the**  
5 **company liable when it was relying on the Department to approve draft IMR language?**

6 A. No. PacifiCare chose to delay compliance until it could devise an EOB that both  
7 contained all the information required by law and achieved PacifiCare's objective of containing  
8 all consumer appeal rights on a single page, while feasible compliance options were plainly  
9 available. If CDI compliance officers had affirmatively stated to PacifiCare that it would not  
10 seek penalties for any EOBs issued during this period of noncompliance, I might have a concern  
11 with seeking penalties now. But there is no evidence of that. To the contrary, CDI repeatedly  
12 informed the company that immediate compliance was the insurer's responsibility, that  
13 PacifiCare had compliant language at its disposal, that CDI does not "approve" insurer  
14 communications to claimants, and that the Department was providing feedback on the  
15 company's drafts as a courtesy.

16 CDI staff devoted significant time and resources to reviewing PacifiCare's draft  
17 EOB language. The Department assists insurers with compliance efforts in order to protect  
18 consumers' rights while preserving insurers' autonomy to run their businesses. If the  
19 Department's willingness to assist PacifiCare with developing a compliant EOB that also met the  
20 company's operational goals were viewed as an excuse for delayed compliance, the Department  
21 would be discouraged from providing this valuable service to insurers.

22 **Q. So your baseline penalty per act in violation of this provision is 35% of**  
23 **\$10,000, or \$3,500?**

24 A. Yes.

1           **Q.     Now, in light of the facts you have been asked to assume and the factors**  
2 **enumerated in section 2695.12, what penalty would you propose for this category of alleged**  
3 **violations?**

4           First, I have seen no evidence of the existence of extraordinary circumstances. (Reg. §  
5 2695.12, sub. (a)(1).) As discussed above, delays connected with the Department’s feedback on  
6 draft EOBs do not constitute “circumstances outside of the control of the licensee” because  
7 PacifiCare could have at any time implemented language they knew to be compliant, for  
8 example, the compliant language that appears on PacifiCare’s other insurance materials; after  
9 PacifiCare was able to draft compliant language that also allowed all consumer appeal rights to  
10 fit on a single EOB page, the company could then implement that language. In any event,  
11 “extraordinary circumstances” are those “which severely and materially affect the licensee’s  
12 ability to conduct normal business operations” (Reg. § 2695.2, subd. (e)), and there is no  
13 evidence of that here.

14           There was also no evidence that these violations were related to the complexity of the  
15 underlying claims. (Reg. § 2695.12, subd. (a)(3).)

16           The fact that every single group claim EOB issued during the period of March 24, 2007,  
17 and June 15, 2007, and every individual claim EOB from March 24 to November 4, 2007, was  
18 noncompliant is an aggravating factor. (Reg. § 2695.12, subd. (a)(7).)

19           I credit PacifiCare for undertaking remedial measures to attempt to revise their EOBs.  
20 (Reg. § 2695.12, subd. (a)(8).) As discussed above, however, PacifiCare could have revised its  
21 EOBs to include existing compliant IMR disclosure immediately, as an interim measure while  
22 developing new language. On the other hand, PacifiCare submitted a draft revised EOB to CDI  
23 on April 20th, a few weeks after CDI initially raised the issue. On balance, this factor is slightly  
24 mitigating.

25           I also considered the existence of previous violations of this kind. (Reg.  
26 § 2695.12, subd. (a)(9).) There were hundreds of thousands of noncompliant EOBs issued  
27 before March 24, 2007. Under Regulation section 2695.1, subdivision (e), PacifiCare is assumed  
28 to have knowledge of the requirement to include the notice of IMR rights. Moreover, even

1 assuming that PacifiCare was operating under the mistaken belief that EOBs are not “letters of  
2 denial,” the requirement that IMR rights be disclosed in “copies of insurer procedures for  
3 resolving grievances” unambiguously applies to the “Know Your Rights” page of PacifiCare’s  
4 EOBs. Even though the deficient EOBs PacifiCare issued prior to March 24 have not been cited  
5 here, they still constitute acts in violation. I therefore view this as a slightly aggravating factor.

6 The harm from these violations appears to be consistent with the harm usually  
7 observed from this type of violation. (Reg. § 2695.12, subd. (a)(10).) The fact that PacifiCare  
8 had appropriate IMR language on other documents sent to members, including at the time they  
9 became eligible to seek an IMR, means that insureds were not completely deprived of this  
10 information. The fact that IMR requests did not increase after June 15, 2007, does not strike me  
11 as significant, because PLHIC’s membership was declining at that time and because the  
12 corrective actions undertaken by the company before that time may have been effective in  
13 improving claim processing accuracy.

14 The Department has found that many consumers who contact the Department based  
15 on the IMR notice benefit from Department intervention even if they never receive an IMR. It is  
16 impossible to ascertain how many consumers would have obtained assistance in this manner if  
17 PacifiCare had compliant EOBs before June 2007, but the evidence that PacifiCare failed to  
18 adequately respond to consumer calls and complaints suggests that the number is not  
19 insignificant. Accordingly, I also consider the underlying harm of claims denials that could have  
20 been remedied, or remedied more quickly, if consumers had more information about the  
21 Department.

22 Under the totality of circumstances, I believe PacifiCare exhibited a good faith  
23 attempt to comply with these Regulations. (Reg. § 2695.12, subd. (a)(12).) PacifiCare submitted  
24 revised drafts quickly in response to feedback from CDI, and implemented revised EOBs quickly  
25 after the new EOBs were finalized. I also considered PacifiCare’s evident belief that it could  
26 delay implementation of new EOBs for an indefinite time until it developed language that met its  
27 single-page requirement and was “approved” by CDI. PacifiCare never sought to confirm its  
28 assumption that it would not be liable for noncompliant EOBs as long as the company was

1 working to come up with a mutually agreeable EOB. On the other hand, PacifiCare had  
2 communicated to CDI that it was awaiting feedback before implementing new draft EOBs.  
3 While it is ultimately the insurer's responsibility to comply with the law and not the  
4 Department's to remind the insurer that each legally deficient EOB may subject the insurer to a  
5 monetary fine, under the totality of the circumstances I consider PacifiCare's good faith efforts to  
6 comply to be a significantly mitigating factor.

7           Since every EOB during the relevant time period was noncompliant, this violation  
8 involves a relatively high frequency of violations. (Reg. § 2695.12, subd. (a)(12).) The severity  
9 of detriment to the public as a whole is difficult to calculate, because it is impossible to know  
10 how many consumers were aware of IMR rights from other sources, how many consumers  
11 would have responded to compliant EOBs by contacting the Department, or how many would  
12 have felt reassured by knowledge of their right to an IMR even if they did not immediately  
13 exercise it. It is reasonable to assume that in the environment of claim problems and non-  
14 compliance encountered by PacifiCare in 2006 and 2007, full disclosure of appeal rights to  
15 PLHIC members would be more important in the case of other insurers with more compliant  
16 operations. Nevertheless, I will conservatively assume that the relative detriment to the public  
17 was not severe.

18           As I stated earlier, I believe the statute gave PacifiCare adequate notice that the  
19 "Know Your Rights" page of each EOB required notice of IMR rights; PacifiCare should have  
20 remediated that omission without regulatory intervention. (Reg. § 2695.12, subd. (a)(13).)

21           On balance, I believe these factors represent a set of mitigating circumstances, as  
22 compared to the generic violation of the EOB notice requirement. However, while I do not  
23 regard the Department's role in assisting PacifiCare to develop a compliant EOB as an excuse  
24 for delayed compliance, to be very conservative I will decrease my recommended penalty by  
25 35%, from \$3,500 to \$2,275 per act in violation.

1           **Q.     So that results in 336,267 acts in violation of the law at \$2,275 per act. Are**  
2 **there any other adjustments you think are appropriate?**

3           A.     Yes. As with the EOP violations, this is an instance of a large number of acts in  
4 violation, in which each additional act does not need to be given the same penalty in order to  
5 arrive at an aggregate penalty that accounts for the harm of each violation and suffices to deter  
6 such violations in the future.

7           I therefore applied the methodology introduced above: reducing the per-act penalty  
8 by 50% after the first 50,000 acts in violation, and continuing to reduce the penalty by 50% after  
9 each additional 50,000 violations. As above, I would not allow the per-act penalty to fall below  
10 \$50, which minimally recognizes that each additional act is an affront to the law. The following  
11 table reflects this calculation.

12

13

<b>Acts in Violation</b>		<b>Penalty per Act in Violation</b>
<b>From</b>	<b>To</b>	
-		\$ 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

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20           In the case of PLHIC's EOB violations, this approach produces an aggregate penalty of  
21 50,000 x \$2,275 + 50,000 x \$1,138 + 50,000 x \$569 + 50,000 x \$284 + 50,000 x \$142 + 50,000  
22 x \$71 + 36,267 x \$50, which equals \$225,763,350. On average, this aggregate value represents a  
23 penalty of \$671 per act in violation. Again, that is a penalty that I would view as too low were  
24 there a single violation, but I think it is a reasonable average over the entire 336,267 violations.  
25 Therefore, my recommended aggregate penalty for this category is \$225,763,350.  
26

27

28

1           **E.     PacifiCare’s Failure to Correctly Pay Claims to UCSF**

2           **Q.     Are you aware of the allegations that PacifiCare failed to correctly pay**  
3 **claims to the UCSF Medical Group in violation of law?**

4           A.     Yes.

5           **Q.     Do incorrect claim payments to providers violate sections of the Insurance**  
6 **Code or the Fair Claims Settlement Practices Regulations?**

7           A.     Yes. Inaccurate claim payments, if committed knowingly or performed with such  
8 a frequency as to indicate a general business practice, constitute violations of Insurance Code  
9 section 790.03, subdivision (h)(1), because inaccurate payments are misrepresentations of  
10 pertinent facts or insurance policy provisions relating to coverage. They are also violations of  
11 section 790.03, subdivision (h)(3), because they reflect failures to adopt and implement  
12 reasonable standards for prompt investigation and processing of claims arising under insurance  
13 policies. They are also violations of section 790.03, subdivision (h)(5), because they are  
14 instances of an insurer not attempting in good faith to effectuate prompt, fair, and equitable  
15 settlements of claims in which liability has become reasonably clear. Underpayments of claims  
16 also violate Regulation section 2695.7, subdivision (g), because they are attempts to settle a  
17 claim by making settlement offers that are unreasonably low.

18           **Q.     In general, how serious an act in violation of law do you view it when a**  
19 **company fails to correctly pay claims?**

20           A.     In comparison to the range of violations to which section 790.035 applies, I view  
21 the incorrect payment violations as being of average seriousness. Paying claims is fundamental  
22 to what insurers are expected to do, and failures to pay claims correctly are serious violations.  
23 Based on my experience, as a general matter, incorrect payments on claims, whether they are  
24 underpayments or overpayments, adversely affect providers. Of course, when claims are  
25 underpaid, claimants are not being reimbursed the amounts they are entitled to. This can result  
26 in adverse financial consequences. In addition, both underpayments and overpayments can  
27 create significant administrative burdens on providers, forcing them, among other things, to  
28 verify the claim payment amounts and to communicate with the insurer about the claim payment

1 errors. And an incorrect payment can result in the patient having to pay more than the  
2 appropriate amount (for example when the provider is incorrectly treated as out-of-network) or  
3 initially pay less than appropriate, resulting in belated billing and potential provider-patient  
4 friction.

5 **Q. Taking all these things into account, where do you place this violation on the**  
6 **section 790.035 spectrum from zero to either \$5,000 or \$10,000 per act in violation.**

7 A. Consistent with my earlier description of this violation as being of average  
8 seriousness, I would put it at 50% of the way from zero to the maximum, or \$2,500 for a non-  
9 willful act in violation and \$5,000 for a willful act in violation.

10 **Q. Now, let me describe for you the background on these violations. Please**  
11 **assume the following facts:**

12 **From at least January 1, 2006, through March 14, 2008, PacifiCare failed to**  
13 **accurately pay certain PPO claims to the UCSF medical group. UCSF notified PacifiCare**  
14 **in June 2007 that certain claims were being paid incorrectly, and PacifiCare agreed that**  
15 **this problem needed to be fixed. But PacifiCare continued to incorrectly pay those UCSF**  
16 **claims until March 15, 2008, when a new contract between UCSF and PacifiCare was**  
17 **executed.**

18 **PacifiCare admitted to UCSF that these claims were being incorrectly paid**  
19 **and that the reason for these mispaid claims was that the company had failed to load the**  
20 **correct fee schedule for UCSF. Though it never disclosed this to UCSF, PacifiCare had**  
21 **been paying UCSF based on the wrong fee schedule for such claims going back as far as**  
22 **2004. PacifiCare never built the fee schedule that it and UCSF agreed to in 2004. UCSF**  
23 **was only aware of incorrect claims payments from January 1, 2006, through March 15,**  
24 **2008. The number of UCSF claims that were incorrectly paid from 2004 to January 1,**  
25 **2006, is unknown. When UCSF asked to have its 2006-2008 claims reprocessed, PacifiCare**  
26 **refused and instead proposed a lump-sum settlement.**

27 **PacifiCare proposed performing a manual claim-by-claim reconciliation, in**  
28 **which PacifiCare and UCSF would each review the claims at issue, one-by-one, to**

1 determine the amount that should have been paid on each claim. Once the parties arrived  
2 at a total number, they would attempt to negotiate a lump-sum settlement. UCSF initially  
3 declined to engage in a claim-by-claim reconciliation because, as UCSF representative  
4 Margaret Martin testified, UCSF was spending an inordinate amount of time on resolving  
5 these PacifiCare issues. Ms. Martin testified that the bulk of UCSF's issues with claims  
6 payments were not with PacifiCare, but with United. Ultimately, however, UCSF did  
7 perform that claim-by-claim reconciliation of these claims, and a lump-sum settlement was  
8 reached for around \$100,000 to \$110,000 for several years' of claims.

9 In response to a subpoena, UCSF produced worksheets reflecting certain  
10 PacifiCare claim payments for dates of service from January 1, 2006, through March 14,  
11 2008. These worksheets reflect claims data and analysis that PacifiCare provided to UCSF  
12 as part of the claim reconciliation process to determine the amounts that PacifiCare  
13 overpaid and underpaid. The number of claims that PacifiCare is alleged to have  
14 incorrectly paid is based on PacifiCare's data reflected in these worksheets. According to  
15 PacifiCare's analysis of those data, from January 1, 2006, through March 14, 2008,  
16 PacifiCare incorrectly paid 3,124 PPO claims to UCSF, of which 2,133 were  
17 underpayments and 991 were overpayments. Of those 3,124 incorrect payments, at least  
18 1,142 were claims that were incorrectly paid after PacifiCare was notified by UCSF of  
19 these claim payment errors. Further, based on PacifiCare's analysis, in 2006, PacifiCare  
20 underpaid claims in the amount of \$47,135.24 and overpaid claims in the amount of  
21 \$66,461.21; in 2007, PacifiCare underpaid claims in the amount of \$164,209.46 and  
22 overpaid claims in the amount of \$40,293.86; and from January 1, 2008, through March 14,  
23 2008, PacifiCare underpaid claims in the amount of \$12,977.56 and overpaid claims in the  
24 amount of \$11,114.92.

25 On March 15, 2008, a new contract between PacifiCare and the University of  
26 California systems became effective. Since then, UCSF has not detected the same level of  
27 claim payment issues.  
28

1           **PacifiCare contends that the UC systems filed a complaint with CDI in order**  
2 **to gain bargaining power in contract negotiations. The UC systems filed a complaint with**  
3 **CDI in May 2007, alleging claims and administrative issues at United and PacifiCare,**  
4 **during a time that PacifiCare and the UC systems were renegotiating provider**  
5 **reimbursement rates. Those negotiations in 2007 ultimately resulted in an increase in rates**  
6 **for all the UC systems of approximately 30 percent. PacifiCare argues that the May 2007**  
7 **complaint against it was filed before UCSF knew of these claims issues with PacifiCare.**  
8 **But that complaint was filed on behalf of not just UCSF, but the entire UC clinical**  
9 **enterprise, including UC Davis Medical Center, UC Irvine Medical Center,**  
10 **UCLA/Westwood Medical Center, UCLA/Santa Monica Medical Center, UC San Diego**  
11 **Medical Center, UCSF Medical Center, and the 5,200 UC physician faculty.**

12           **PacifiCare also contends that UCSF's claims were complex because UCSF**  
13 **was being paid on a nonstandard fee schedule during the time of the incorrect claims**  
14 **payments. That agreed-to fee schedule, however, was proposed by PacifiCare, and**  
15 **PacifiCare represented to UCSF that it could correctly load that nonstandard fee schedule.**  
16 **PacifiCare also contends that the fact that the UCSF medical group had 18 taxpayer**  
17 **identification numbers (TINs) created more administrative burdens and caused greater**  
18 **potential for confusion.**

19           **During the time that UCSF and PacifiCare were attempting to resolve these**  
20 **claim payment issues, UCSF and PacifiCare/United representatives had regularly**  
21 **scheduled meetings or calls to address these issues. Ms. Martin testified that during this**  
22 **period, PacifiCare/United employees worked with UCSF to identify and resolve these**  
23 **claims payment issues; in particular, Ms. Martin testified that she believed that PacifiCare**  
24 **employee Anne Harvey was honest and responsive.**

25           **First, given this information, were these acts knowingly committed or**  
26 **performed with such frequency as to indicate a general business practice?**

27           A.     Yes. These acts were knowingly committed. The company is chargeable with  
28 knowledge that it had failed to build the correct fee schedule for UCSF and that it was paying

1 UCSF according to the wrong fee schedule, either of which is sufficient to establish that  
2 PacifiCare knowingly committed these unfair acts. PacifiCare knew or should have known that  
3 it was misrepresenting pertinent facts and not attempting in good faith to effectuate prompt, fair,  
4 and equitable settlements of these claims by incorrectly paying each of these claims.

5 **Q. Based on the information you have been given, was the issuance, amendment,**  
6 **or servicing of the policy or endorsement inadvertent, as that term is used in section**  
7 **790.035?**

8 A. No. I saw no evidence that the issuance of each claim payment (i.e., the EOP and  
9 enclosed check) was inadvertent. PacifiCare intended to service its policies by sending those  
10 documents.

11 **Q. Given this information, do you classify these violations as willful or non-**  
12 **willful?**

13 A. The 1,142 claims processed after June 2007, when UCSF notified PacifiCare that  
14 its claims were being processed improperly, are willful acts in violation. Once PacifiCare was  
15 informed that it was paying UCSF at the wrong rate and continued to do so rather than to  
16 implement the agreed-upon fee schedule, PacifiCare acted with a purpose or willingness to not  
17 effectuate prompt, fair, and equitable settlements of UCSF's claims. It also willingly  
18 misrepresented the amount owed to UCSF and its affiliated providers, and purposely refused to  
19 adopt reasonable standards for handling UCSF's claims — in this case, building the correct fee  
20 schedule for which the parties had contracted. The company may well have been aware that it  
21 had failed to build the fee schedule or that it was paying these claims incorrectly before that date  
22 as well, but I will assume that the violations in June 2007 and before were non-willful.

23 **Q. Now, in light of the facts you have been asked to assume and the factors**  
24 **enumerated in section 2695.12, what penalty would you propose for this category of alleged**  
25 **violations?**

26 First, I have seen no evidence of the existence of extraordinary circumstances  
27 (Reg. § 2695.12, subd. (a)(1)), as that term is defined by the Regulations (Reg. § 2695.2,  
28 subd. (e)).

1 I also did not see evidence that these UCSF claims were complex. (Reg.  
2 § 2695.12, subd. (a)(3).) PacifiCare is a health insurer in the business of paying claims, and the  
3 process of paying claims according to the correct fee schedules should not be complex for the  
4 company. In addition, even if UCSF's nonstandard fee schedule and the number of TINs used  
5 by UCSF did affect the complexity of paying UCSF claims, those factors were irrelevant to  
6 PacifiCare's incorrect payment of the UCSF claims at issue here. PacifiCare mispaid these  
7 claims not because of the type of fee schedule or the number of TINs, but rather because  
8 PacifiCare had failed to build and load the correct fee schedule that PacifiCare and UCSF had  
9 agreed to in 2004.

10 The relative number of claims where the noncomplying acts were found to exist is  
11 inapplicable to this set of violations. (Reg. § 2695.12, subd. (a)(7).) For these UCSF claims,  
12 100 percent of the claims reviewed contained noncomplying acts. It would be inappropriate to  
13 consider this an aggravating factor, however, because the Department was provided only those  
14 claims that were incorrectly paid.

15 That PacifiCare did ultimately reach a settlement with UCSF is some evidence of  
16 the company taking remedial measures. (Reg. § 2695.12, subd. (a)(8).) However, I also took  
17 into consideration the fact that PacifiCare never built or loaded the correct fee schedule for  
18 UCSF and refused to reprocess UCSF's incorrectly paid claims. Reprocessing UCSF's claims  
19 according to the correct, agreed-to fee schedule would have been the most appropriate remedial  
20 measure here. Because the incorrectly paid claims were never reprocessed, the amounts that  
21 UCSF patients paid on PacifiCare's incorrectly processed claims likely could not be adjusted.  
22 Further, PacifiCare never disclosed to UCSF that the company had been paying claims according  
23 to the wrong fee schedule as far back as 2004. Claims mispaid from 2004 to 2006 were not part  
24 of the settlement, and therefore never remediated. This is a slightly aggravating factor.

25 For the reasons previously discussed, the existence or nonexistence of previous  
26 violations factor is inapplicable in this case. (Reg. § 2695.12, subd. (a)(9).)

27 There is evidence of harm caused by these violations greater than the generic  
28 violation for incorrectly paying claims. (Reg. § 2695.12, subd. (a)(10).) In total, from January 1,

1 2006, through March 15, 2008, PacifiCare underpaid UCSF claims in the amount of  
2 \$224,322.26, and overpaid UCSF claims in the amount of \$117,869.99. I did consider the fact  
3 that UCSF is a large provider group for which those amounts would not be as financially  
4 significant as they would be for a smaller group or for an individual member. But these  
5 thousands of incorrect payment violations imposed significant administrative burdens on UCSF.  
6 Although UCSF did not want to, it was ultimately forced to perform a claim-by-claim  
7 reconciliation of over three thousand claims in order to remediate PacifiCare's mistakes.  
8 Requiring providers to contribute to the costs of correcting insurer errors for which the providers  
9 were not responsible is an example of the insurer's unfair externalization of its costs of doing  
10 business, displacing those costs onto providers. Further, there is an unknown number of claims  
11 that PacifiCare incorrectly paid from 2004 to 2006, because it had failed to build and load the  
12 correct fee schedule. Thus, there is harm caused by these mispaid claims is not being accounted  
13 for in the generic violation. Moreover, in the typical case, an insurer that mispays claims is  
14 willing to reprocess them. Because PacifiCare refused to do so here, there was also potential  
15 harm to patients who paid their portion for UCSF claims based on incorrect amounts that  
16 PacifiCare had erroneously paid; this financial harm was not quantified (or remediated) because  
17 of PacifiCare's refusal to reprocess these claims. This is an aggravating factor.

18 Under the totality of circumstances, I do not believe PacifiCare exhibited a good faith  
19 attempt to comply with these Regulations. (Reg. § 2695.12, subd. (a)(12).) UCSF notified  
20 PacifiCare that its claims were being incorrectly paid in June 2007, yet PacifiCare continued to  
21 incorrectly pay UCSF claims until March 15, 2008, when a new contract became effective. That  
22 is evidence of bad faith. Further, PacifiCare refused UCSF's request to have these incorrect  
23 claim payments reprocessed, apparently because it would take too much effort to build and load  
24 the correct fee schedule. That is further evidence of bad faith. I did consider Ms. Martin's  
25 testimony that PacifiCare was willing to work with UCSF to identify and resolve these claims  
26 problems, and that Ms. Martin found Ms. Harvey to be honest and responsive. I consider these  
27 to be slightly mitigating factors. In my experience, cooperation by an insurer — after claims  
28 problems have been brought to its attention — is expected and does not necessarily show good

1 faith by the insurer; I further expect all employees of an insurer to be honest and responsive  
2 when dealing with claimants. I also took into consideration that PacifiCare admitted to UCSF  
3 that the reason for the incorrect payments was that the insurer had failed to load the correct fee  
4 schedule. This is not, however, a mitigating factor. The fact that PacifiCare disclosed the root  
5 cause of the claim payment errors after UCSF brought those errors to PacifiCare's attention does  
6 not satisfy the test of good faith. In fact, PacifiCare's failure to disclose to UCSF that the insurer  
7 had failed to build the fee schedule and had been paying UCSF claims according to the wrong  
8 fee schedule since 2004 is evidence of bad faith. Further, PacifiCare's willingness to do a  
9 manual claim-by-claim reconciliation instead of reprocessing the claims is only slight evidence  
10 of good faith; once it was determined that PacifiCare had incorrectly processed these claims, it  
11 was under an obligation to reprocess those claims. By refusing to reprocess those claims, and  
12 instead pursuing a claim-by-claim reconciliation and a lump-sum settlement, PacifiCare imposed  
13 administrative burdens on UCSF that UCSF should not have been forced to take on because of  
14 PacifiCare's mistakes. This is an aggravating factor.

15 Based on my experience, incorrectly paying 3,124 claims over the course of two  
16 years and three months reflects a high frequency. (Reg. § 2695.12, subd. (a)(12).) The severity  
17 of detriment to the public as a whole is unknown; since PacifiCare never reprocessed these  
18 claims, it is unclear if or how patients were affected. Nevertheless, I will conservatively assume  
19 that the detriment to the public in this case was no different from the generic case.

20 In this instance, PacifiCare was aware that it was incorrectly paying UCSF claims at  
21 least as early as June 2007, but failed to remediate this issue, causing over a thousand additional  
22 claims to be incorrectly paid until March 15, 2008. (Reg. § 2695.12, subd. (a)(13).) Indeed,  
23 PacifiCare never remediated the root cause of these claim payment errors: that it had never built  
24 and loaded the correct fee schedule that it had agreed to with UCSF. This prevented PacifiCare  
25 from fully remediating these claim payment errors by reprocessing the claims.

26 On balance, I find that these factors represent a set of circumstances that are  
27 aggravating, as compared to the generic incorrect payment violation. I think it appropriate to  
28 increase the per violation penalty by at least 20 percent, from \$2,500 to \$3,000 for each of the

1 1,982 non-willful acts, and from \$5,000 to \$6,000 for each of the 1,142 willful acts. Therefore,  
2 my recommended aggregate penalty for this category is \$12,798,000, for these 3,124 violations.

3 **F. PacifiCare's Failure to Correctly Pay Claims to UCLA**

4 **Q. Are you aware of the allegations that PacifiCare failed to correctly pay**  
5 **claims to the UCLA Medical Group in violation of law?**

6 A. Yes.

7 **Q. Do underpayments of claim to providers violate sections of the Insurance**  
8 **Code or the Fair Claims Settlement Practices Regulations?**

9 A. Yes. Like incorrect payments of claims, underpayments of claims violate  
10 Insurance Code section 790.03, subdivisions (h)(1), (h)(3), and (h)(5), and Regulation section  
11 2695.7, subdivision (g), for the reasons I discussed above.

12 **Q. As a general proposition, how serious an act in violation of law do you view it**  
13 **to be when a company underpays claims to providers?**

14 A. In comparison to the range of violations to which section 790.035 applies, I view  
15 claim-underpayment violations as being of average seriousness. As I have previously stated,  
16 paying claims is fundamental to what insurers are supposed to do, and failures to pay claims  
17 correctly are serious violations. Based on my experience, as a general matter, underpayments on  
18 claims adversely affect providers. When claims are underpaid, providers are not being  
19 reimbursed the amounts they are entitled to. This can result in adverse financial consequences.  
20 In addition, underpaid claims can create significant administrative burdens on providers, forcing  
21 them, among other things, to verify the claim payment amounts and to communicate with the  
22 insurer about the claim payment errors.

23 **Q. Taking all these things into account, where do you place this violation on the**  
24 **section 790.035 spectrum from zero to either \$5,000 or \$10,000 per act in violation.**

25 A. Consistent with my earlier description of this violation as being of average  
26 seriousness, I would put it at 50% of the way from zero to the maximum, or \$2,500 for a non-  
27 willful act in violation and \$5,000 for a willful act in violation.

28

1           **Q.     Now, let me describe for you the background on these violations arising from**  
2 **underpayment of claims to UCLA. Please assume the following facts:**

3                   **From at least the beginning of 2007 through March 14, 2008, PacifiCare**  
4 **systematically underpaid PPO claims submitted by the UCLA medical group. In**  
5 **September 2007, UCLA representatives audited PLHC’s claims payment for 2007 and**  
6 **found a significant number of underpayments. UCLA began submitting appeal letters to**  
7 **PacifiCare for those underpaid claims, but did not get responses from PacifiCare. After**  
8 **some time, the number of underpaid claims became so significant that UCLA started**  
9 **sending multipage spreadsheets to PacifiCare listing the underpaid claims, rather than**  
10 **individual appeal letters. At PacifiCare’s request, UCLA produced at the hearing these**  
11 **spreadsheets of underpaid claims, which covered dates of service from January 2007**  
12 **through March 14, 2008. According to these spreadsheets, PacifiCare underpaid at least**  
13 **1,333 claims during this period; the total amount underpaid on these 1,333 claims was**  
14 **\$199,923.36. Of these 1,333 underpaid claims, at least 572 were incorrectly paid after**  
15 **UCLA notified PacifiCare of these claims errors.**

16                   **Around the same time that UCLA discovered that PacifiCare was**  
17 **underpaying these claims, UCLA also discovered that a large number of its providers were**  
18 **not listed as participating providers on PacifiCare’s online provider database. This was a**  
19 **likely cause for many of the incorrect claim payments that PacifiCare had been making:**  
20 **providers not listed on PacifiCare’s database as UCLA providers would not be paid based**  
21 **on the UCLA contract, but likely based on another fee schedule or a default fee schedule.**  
22 **James Rossie, an assistant director at UCLA, testified at the hearing that UCLA had been**  
23 **sending PacifiCare, on a monthly basis, updated rosters of UCLA participating providers**  
24 **— which included information such as provider name, license number, NPI, tax**  
25 **identification number, and office locations — with the understanding that PacifiCare**  
26 **would update its database to accurately reflect those provider data. PacifiCare apparently**  
27 **didn’t do that. Mr. Rossie also testified that the monthly rosters included all the**  
28 **information that PacifiCare would need to correctly update its provider database.**

1 **PacifiCare now contends that these monthly rosters were not in the format that the**  
2 **company preferred, though it does not claim that the rosters were missing any information**  
3 **necessary to update the company’s provider database. Mr. Rossie testified that, to his**  
4 **knowledge, PacifiCare never informed anyone at UCLA that the insurer was unable to use**  
5 **the information in monthly rosters that UCLA was sending to update the provider**  
6 **database.**

7 **After discovering these omissions of UCLA providers from PacifiCare’s**  
8 **provider database, UCLA was forced to spend significant time working with PacifiCare on**  
9 **a roster reconciliation project. This project spanned six to seven months, from around the**  
10 **Fall of 2007 to Spring 2008 and required UCLA and PacifiCare to go through PacifiCare’s**  
11 **provider database, TIN-by-TIN, to validate the data for UCLA providers. PacifiCare**  
12 **witness Lisa Lewan testified that this project took “[a] lot of staff time.” Mr. Rossie**  
13 **testified that this project imposed burdens on UCLA staff to correct PacifiCare’s errors**  
14 **that UCLA was not used to having to do: “We were being asked to review PacifiCare’s**  
15 **errors of adding and deleting doctors, updating information, reconciling TINs, the**  
16 **addresses, the phone numbers, the doctor’s specialty on several years’ of errors that**  
17 **accumulated. And it took time for UCLA to go through that. We don’t have a staff that’s**  
18 **dedicated to correcting payor errors. So it was finding personnel to go through that —**  
19 **several files. Some of them are much larger than others, but a large number of files had to**  
20 **be reviewed and all that data compared to our roster.”**

21 **According to UCLA, as a result of this roster reconciliation project, there**  
22 **were several hundred UCLA physicians that needed to be added or deleted from**  
23 **PacifiCare’s online directory. According to PacifiCare, there were only 16 records that**  
24 **needed to be corrected.**

25 **Ultimately, PacifiCare settled with UCLA to resolve these underpaid claims.**

26 **PacifiCare has contended that the fact that the UCLA medical group had**  
27 **around 118 TINs makes processing UCLA claims more complex. PacifiCare has also**  
28 **contended that the fact that UCLA medical group comprises approximately 1,600**

1 **physicians, and has what PacifiCare characterizes as a high turnover rate, further**  
2 **complicates claim processing. PacifiCare has also asserted that UCLA was responsible for**  
3 **significant delays in confirming information related to the roster reconciliation project,**  
4 **including taking over three months to verify four TINs. PacifiCare has further asserted**  
5 **that it worked cooperatively with UCLA to resolve these claim payment issues and other**  
6 **UCLA concerns, including holding regular monthly meetings with UCLA.**

7 **First, given this information, were these acts knowingly committed or**  
8 **performed with such frequency as to indicate a general business practice?**

9 A Yes, these acts were knowingly committed. The facts I have been asked to  
10 assume indicate that PacifiCare had been receiving but not using regular provider updates  
11 UCLA had been submitting. PacifiCare knew or should have known that failing to update its  
12 provider rosters for UCLA would result in UCLA providers being paid incorrectly. Moreover, a  
13 health insurer has implied or constructive knowledge of how much its contracts required it to  
14 pay contracting providers. Absent evidence that PacifiCare had a reasonable basis to be  
15 unaware that it was incorrectly paying these claims, the company knowingly committed these  
16 misrepresentations of pertinent facts, knowingly failed to adopt and implement reasonable  
17 standards for the prompt investigation and process of claims, and knowingly failed to attempt in  
18 good faith to effectuate prompt, fair, and equitable settlements of claims. Indeed, UCLA gave  
19 PacifiCare actual knowledge as of September 2007 that the insurer was incorrectly paying these  
20 claims.

21 This set of violations also represents an example of violations performed with  
22 such frequency as to indicate a general business practice. Here the business practices were  
23 explicit and directly resulted in the violations. PacifiCare's computer systems were set up to pay  
24 UCLA claims, which represented a form of business practice in and of itself. Under the  
25 circumstances encountered, those systems unflinchingly produced an incorrect payment. Thus, we  
26 need not infer the business practice from claim frequency, it is directly implied from the manner  
27 in which such claims are paid. However, we also have the additional facts I have been asked to  
28

1 assume, that at least 1,333 claims were underpaid. That certainly is a frequency sufficient to  
2 indicate a general business practice.

3 **Q. Based on the information you have been given, was the issuance, amendment,**  
4 **or servicing of the policy or endorsement inadvertent, as that term is used in section**  
5 **790.035?**

6 A. No. I saw no evidence that the servicing of the underlying claims by issuing each  
7 EOP and enclosed check was inadvertent. PacifiCare intended to service its policies by sending  
8 those documents.

9 **Q. Do you classify these claim-underpayment violations as willful or non-**  
10 **willful?**

11 A. The 572 claims incorrectly paid after UCLA notified PacifiCare that a significant  
12 number of claims were being underpaid, are willful acts in violation. After being notified that it  
13 was systematically paying these claims incorrectly, PacifiCare willfully continued to mispay  
14 these claims. In fact, based on the information I have been given, UCLA attempted on multiple  
15 occasions to notify PacifiCare of these claim payment errors, but PacifiCare didn't even  
16 respond, much less remediate the errors. I will consider the other 761 underpaid claims to be  
17 non-willful acts in violation.

18 **Q. Now, in light of the facts you have been asked to assume and the factors**  
19 **enumerated in section 2695.12, what penalty would you propose for this category of alleged**  
20 **violations?**

21 A. First, I have seen no evidence of the existence of extraordinary circumstances  
22 (Reg. § 2695.12, subd. (a)(1)), which is defined by the Regulations to mean "circumstances  
23 outside of the control of the licensee which severely and materially affect the licensee's ability  
24 to conduct normal business operations" (Reg. § 2695.2, subd. (e)).

25 I also did see some evidence that these UCLA claims were complex. (Reg. §  
26 2695.12, subd. (a)(3).) I have considered PacifiCare's assertion that this provider group had a  
27 significant number of TINs and physicians, with potentially high turnover. Assuming these to be  
28 true, I consider that to be a slightly mitigating factor. PacifiCare is a health insurer in the

1 business of paying claims, and the process of paying claims according to the correct fee  
2 schedules should not be complex for the company. Further, these are aspects of the UCLA  
3 medical group that PacifiCare was aware, or should have been aware, of before it contracted  
4 with UCLA. If PacifiCare believed these aspects would create difficulties for it to pay claims  
5 correctly, it should not have agreed to do so, or contractually required UCLA to take action that  
6 would have enabled it to pay claims correctly, or should have taken other measures in advance to  
7 ensure that claims would be paid accurately despite these asserted challenges.

8 The relative number of claims where the noncomplying acts were found to exist is  
9 inapplicable to this set of violations. (Reg. § 2695.12, subd. (a)(7).) For these UCLA claims,  
10 100 percent of the claims reviewed contained noncomplying acts. It would be inappropriate to  
11 consider this an aggravating factor, however, because the Department was provided only those  
12 claims that were underpaid.

13 That PacifiCare did ultimately reach a settlement with UCLA is evidence of the  
14 company taking remedial measures. (Reg. § 2695.12, subd. (a)(8).) Though reprocessing  
15 UCLA's claims would have been the most appropriate remedial measure here, I will not count  
16 PacifiCare's failure to do so against it because I saw no evidence that UCLA requested that these  
17 claims be reworked, as was the case with UCSF. Also, the fact that PacifiCare engaged in a  
18 roster reconciliation project to correct the errors and omissions in its provider database is  
19 evidence of the company taking remedial measures. So I consider the reconciliation and the  
20 eventual settlement to be mitigating factors.

21 For the reasons previously discussed, the existence or nonexistence of previous  
22 violations factor is inapplicable in this case. (Reg. § 2695.12, subd. (a)(9).)

23 There is evidence of harm caused by these specific violations greater than the  
24 ordinary case. (Reg. § 2695.12, subd. (a)(10).) From January 1, 2007, through March 14, 2008,  
25 PacifiCare underpaid over one thousand claims, totaling close to \$200,000 in underpayments.  
26 There was also potential harm to patients who paid their portion for UCLA claims based on  
27 incorrect amounts that PacifiCare had erroneously paid; this harm was not quantified (or  
28 remediated) because PacifiCare did not reprocess these claims. In the ordinary case, incorrectly

1 paid claims are ultimately reprocessed, and all parties are correctly compensated. I also  
2 considered that UCLA is a large provider group for which the amounts at issue would not be as  
3 significant financially as they would be for a smaller group or a single practitioner. However,  
4 for patients who likely would have been affected in the amounts they had to pay, those amounts  
5 may have been financially significant. In addition, even if the amounts of underpayment didn't  
6 financially harm UCLA, these incorrect payments imposed significant administrative burdens on  
7 UCLA. In order to correct PacifiCare's mistakes, UCLA was forced to engage in a time-  
8 consuming and labor-intensive roster reconciliation that spanned six to seven months.

9 Under the totality of circumstances, I do not believe PacifiCare exhibited a good  
10 faith attempt to comply with these Regulations. (Reg. § 2695.12, subd. (a)(12).) PacifiCare's  
11 failure to update its provider databases based on the monthly rosters UCLA was sending it is  
12 evidence of the absence of a good faith attempt to comply. PacifiCare knew or should have  
13 known that this failure would likely result in incorrect claim payments. PacifiCare's willingness  
14 to perform a roster reconciliation project, the effort it expended in doing so, and its assertion that  
15 it worked cooperatively with UCLA to resolve issues are only slightly mitigating factors. These  
16 efforts were only made after claim payment errors were brought to its attention, and after  
17 inaccuracies with its provider database were brought to its attention. Further, these are actions  
18 that I would expect an insurer to undertake, at a minimum, to correct its own mistakes.  
19 PacifiCare's contentions that UCLA was responsible for delays in verifying certain information  
20 during the roster reconciliation project do not show good faith on PacifiCare's part and they do  
21 not excuse PacifiCare mistakes in the first instance. However, I will consider UCLA's purported  
22 delay as a mitigating factor to the extent it prevented PacifiCare from remediating these errors  
23 sooner, even though PacifiCare has not shown that it would have been able to remediate these  
24 underpayments before March 15, 2008. Indeed, it appears that the systemic underpayment of  
25 UCLA claims was remediated on or around March 15, 2008, not because of any of the remedial  
26 measures the company had taken, but because of the new provider contract between the UC  
27 systems and PacifiCare that became effective on that date.

1           Based on my experience, incorrectly paying 1,333 claims over the course of one  
2 year and two months reflects a high frequency. (Reg. § 2695.12, subd. (a)(12).) The severity of  
3 detriment to the public as a whole is unknown; since PacifiCare never reprocessed these claims,  
4 it is unclear if or how patients were affected. Nevertheless, I will conservatively assume that the  
5 detriment to the public was no different than the detriment from the generic violation.

6           In this instance, PacifiCare was aware that it was incorrectly paying UCLA claims  
7 at least as early as September 2007, yet claims continued to be underpaid through at least  
8 March 14, 2008, and the roster reconciliation project was not completed until around the same  
9 time in March 2008. (Reg. § 2695.12, subd. (a)(13).) I nevertheless credit PacifiCare's assertion  
10 that UCLA was responsible for some of the delays in completing the roster reconciliation  
11 project. I do not fault UCLA for needing time to perform its tasks related to the roster  
12 reconciliation project, burdens that UCLA should not have been forced to undertake in the first  
13 place. But I will not consider the delay in remediating these errors to be an aggravating  
14 circumstance. As I previously noted, however, PacifiCare never took the most appropriate  
15 remedial measure, which would have been to reprocess all these claims. Overall, I consider this  
16 factor neither aggravating nor mitigating.

17           On balance, I find that these factors represent a set of circumstances that are  
18 aggravating, as compared to the generic violation for the underpayment of claims. I therefore  
19 think it appropriate to increase the per violation penalty by 15%, from \$2,500 to \$2,875 for each  
20 of the 761 non-willful acts in violation, and from \$5,000 to \$5,750 for each of the 572 willfull  
21 acts in violation. Therefore, my recommended aggregate penalty for this category is \$3,832,375,  
22 for these 1,333 violations.

23           **G. PacifiCare's Failure to Respond to Claims Submitted by UCLA**

24           **Q. Are you aware of the allegations that PacifiCare failed to respond to claims**  
25 **submitted by the UCLA Medical Group in violation of law?**

26           A. Yes.

1           **Q. Does the failure to respond to claims violate sections of the Insurance Code**  
2 **or the Fair Claims Settlement Practices Regulations?**

3           A. Yes. The failure to respond to claims submitted by providers, if committed  
4 knowingly or performed with such a frequency as to indicate a general business practice,  
5 constitutes a violation of Insurance Code section 790.03, subdivision (h)(2), which requires  
6 insurers to acknowledge and act reasonably promptly upon communications with respect to  
7 claims arising under insurance policies. They are also violations of section 790.03, subdivision  
8 (h)(3), because not responding to submitted claims reflects failures to adopt and implement  
9 reasonable standards for prompt investigation and processing of claims arising under insurance  
10 policies. They are also violations of section 790.03, subdivision (h)(4), because they are  
11 instances of an insurer failing to affirm or deny coverage of claims within a reasonable time.  
12 They also violate sections 10123.13, subdivision (a), and 10123.147, subdivision (a), which  
13 require insurers to reimburse, contest, or deny claims within 30 working days after receipt.

14           **Q. As a general proposition, how serious an act in violation of the law do you**  
15 **view it to be when a company fails to respond to claims submitted by a provider?**

16           A. In comparison to the range of violations to which section 790.035 applies, I view  
17 failing to respond to claims as being of average seriousness. Responding to submitted claims, as  
18 part of the process of paying claims, is fundamental to what insurers are supposed to do. Based  
19 on my experience, as a general matter, these types of violations can result in adverse financial  
20 consequences for providers because claim payments are being delayed. In addition, these  
21 failures can create significant administrative burdens on providers, because they must track down  
22 these claims and ensure that the insurer received them.

23           **Q. As a general proposition, where do you place this type of violation on the**  
24 **section 790.035 spectrum from zero to either \$5,000 or \$10,000 per act in violation?**

25           A. Consistent with my description of this type of violation as being of average  
26 seriousness, I would put it at 50% of the way from zero to the maximum, or \$2,500 per act for  
27 non-willful acts and \$5,000 per act for willful acts.

28

1           **Q. Let me describe for you the background of these failure-to-respond**  
2 **violations. Please assume the following facts:**

3           **For over 17 months, from at least March 15, 2008, through August 31, 2009,**  
4 **PacifiCare failed to respond to many PPO claims submitted by UCLA. In November 2009,**  
5 **shortly after discovering a large number of claims that PacifiCare had failed to respond to,**  
6 **UCLA forwarded to PLHIC spreadsheets of those unresponded-to claim lines to request**  
7 **that they be processed. PacifiCare initially rejected that request on the grounds that the**  
8 **company couldn't identify some of the members on the spreadsheets as PacifiCare PPO**  
9 **members. But when UCLA reviewed a random sample of the claim lines, it was able to**  
10 **identify all the members except one, using the PacifiCare online provider portal. When**  
11 **Mr. Rossie initially testified in February 2010, these claims had yet to be paid.**

12           **After Mr. Rossie testified, PacifiCare reviewed and analyzed the claim lines**  
13 **in the spreadsheets that UCLA had submitted in November 2009. Though PacifiCare had**  
14 **rejected UCLA's request in November 2009 to process these claim lines on the grounds that**  
15 **it couldn't identify the members, this time PacifiCare was able to process these claims. Mr.**  
16 **Rossie testified that no additional member information was provided by UCLA regarding**  
17 **these claim lines from November 2009 until PacifiCare ultimately processed them. Based**  
18 **on PacifiCare's review, there were in total 2,405 PPO claim lines in UCLA's spreadsheets**  
19 **of unresponded-to claims, of which 23 required PacifiCare to make payments, and some**  
20 **unknown number required PacifiCare to apply amounts to the members' deductible. In**  
21 **total, PacifiCare admitted it was required to make \$11,190.95 in claim payments and**  
22 **allowed amounts applied to member deductibles. PacifiCare contends, however, that the**  
23 **vast majority of these claims were not entitled to payment; in particular, 1,230 of these**  
24 **claim lines related to a "modifier 26" service that PacifiCare does not cover. PacifiCare**  
25 **also claims that 98.8% of the claim lines did not require payment, but it is unclear whether**  
26 **that figure includes claims that PacifiCare accepted coverage on but applied the full**  
27 **amount to the deductible.**

1                   **PacifiCare has contended that the fact that UCLA submits claims on a claim-**  
2 **line basis instead of an entire-claim basis makes claim processing complex because**  
3 **PacifiCare might not be able to identify and match a member. PacifiCare has also**  
4 **contended that it did respond to these claim lines by sending EOBs. PacifiCare produced**  
5 **two EOBs at the hearing that appeared to correspond to two claim lines on UCLA's**  
6 **spreadsheets of unresponded-to claims. Mr. Rossie testified that UCLA's records reflect**  
7 **that it never received these EOBs at the time it submitted to PacifiCare its spreadsheets of**  
8 **unresponded-to claims. Mr. Rossie further testified that before his testimony at the**  
9 **hearing, PacifiCare never showed UCLA any EOBs for any of the claim lines that UCLA**  
10 **had asserted had not been responded to. Other than those two EOBs produced at the**  
11 **hearing, PacifiCare has offered no evidence that it responded to any of these UCLA claim**  
12 **lines until it processed the claims in 2010, after Mr. Rossie testified at the hearing.**

13                   **First, given this information, were these acts knowingly committed or**  
14 **performed with such frequency as to indicate a general business practice?**

15                   A.     Yes, these acts were knowingly committed. Mr. Rossie testified that these claims  
16 were submitted. An insurer is chargeable with knowledge of claims it has actually received.  
17 Furthermore, the thousands of claims represent a frequency that indicates a general business  
18 practice.

19                   **Q.     Based on the information you have been given, was the issuance, amendment,**  
20 **or servicing of the policy or endorsement inadvertent, as that term is used in section**  
21 **790.035?**

22                   A.     No. I saw no evidence that PacifiCare's failure to respond to these thousands of  
23 claim lines was an inadvertent issuance, amendment, or servicing of a policy. Under a literal  
24 reading of section 790.035, PacifiCare's failure to respond to these claim lines would not  
25 constitute any type of issuance, amendment, or servicing of the policy. By failing to respond to  
26 claims, PacifiCare is actually not servicing the policy, so this provision wouldn't apply.  
27 However, even if I were to consider a failure to service a policy to be within the statute, I did not  
28 see any evidence here that PacifiCare inadvertently failed to service the policy.

1           **Q.     Given this background information, do you classify these violations as willful**  
2 **or non-willful?**

3           A.     I will consider these violations to be non-willful. Even though PacifiCare clearly  
4 had constructive knowledge that it had received these claims and should be processing them, I  
5 did not see evidence that it willfully failed to respond to these claims when they were initially  
6 submitted. I would consider PacifiCare's failures to respond to and process UCLA's appeal  
7 letters and the spreadsheets that were submitted to PacifiCare in November 2009, to be willful  
8 acts, but I understand that the Department is not charging those as separate acts in violation.  
9 Accordingly, I consider this category of violations to be non-willful.

10           **Q.     Given this background information, what penalty would you propose for this**  
11 **category of violations?**

12           A.     First, I have seen no evidence of the existence of extraordinary circumstances  
13 (Reg. § 2695.12, subd. (a)(1)), as that term is defined in the Regulations (Reg. § 2695.2, subd.  
14 (e)).

15           I also did not see evidence that responding to these claims would have been complex, or  
16 even that these claims in general were complex. (Reg. § 2695.12, subd. (a)(3).) PacifiCare is a  
17 health insurer in the business of paying claims, and simply responding to claims that are  
18 submitted should not be complex for the company. Indeed, although PacifiCare claimed to be  
19 unable to process these claim lines in response to UCLA's November 2009 request, it was able  
20 to do so after Mr. Rossie testified in 2010. Based on my experience, I also do not believe that  
21 UCLA's practice of submitting on a claim-line basis would make responding to these claims  
22 complex. PacifiCare could respond to a claim line even if it was unable to identify a member;  
23 that response, for instance, could ask for additional information about the member. And, as a  
24 general matter, an insurer has the ability to specify in its contract the manner of claim-  
25 submission. I have been given no assumption that PacifiCare thought it necessary to do so with  
26 its UCLA contract.

27           The relative number of claims where the noncomplying acts were found to exist  
28 factor is inapplicable to this set of violations. (Reg. § 2695.12, subd. (a)(7).) For these UCLA

1 claims, 100 percent of the claims reviewed contained noncomplying acts. It would be  
2 inappropriate to consider this an aggravating factor, however, because the Department was  
3 provided only claim lines that had not been responded to.

4 That PacifiCare did ultimately reprocess these claims is evidence of the company  
5 taking remedial measures. (Reg. § 2695.12, subd. (a)(8).) I consider this to be only a slightly  
6 mitigating factor because PacifiCare initially refused to process these claims when UCLA  
7 requested in November 2009, and only did so after UCLA raised these issues with the  
8 Department and testified at the hearing.

9 For the reasons previously discussed, the existence or nonexistence of previous  
10 violations factor is inapplicable in this case. (Reg. § 2695.12, subd. (a)(9).)

11 There is evidence of harm caused by these specific violations greater than the  
12 generic violation. (Reg. § 2695.12, subd. (a)(10).) I considered PacifiCare's analysis showing  
13 that 98.8% of the unresponded-to claims did not require payment. The primary harm here,  
14 however, was that for over a year, from March 2008 to August 2009, PacifiCare failed to  
15 respond to thousands of claim lines submitted by UCLA. Assuming PacifiCare's analysis to be  
16 accurate, the fact that a high percentage of these claims did not ultimately require payment does  
17 not mean that PacifiCare was entitled to ignore these claims. Claimants are entitled to have their  
18 claims processed, and processed timely; PacifiCare's failure to respond to so significant a  
19 number of claims imposed administrative burdens on UCLA to track down these claims and to  
20 submit and re-submit requests to have them processed. Moreover, PacifiCare admits that it was  
21 required to issue \$11,190.95 in additional payments to UCLA and in allowed amounts to  
22 member deductibles. Thus, both the UCLA medical group and UCLA patients were harmed by  
23 PacifiCare's failure to respond to these claims, some of which were submitted as early as March  
24 2008, but not processed until 2010. I considered that UCLA is a large provider group for which  
25 the amounts at issue would not be as significant financially as they would be for a smaller group  
26 or a single practitioner. However, for patients who were affected in the amounts they had to pay,  
27 those amounts may have been financially significant. To the extent that PacifiCare argues that  
28 there was no harm here because it did in fact respond to each of these claim lines, I do not

1 believe that showing Mr. Rossie two EOBs that the company contended it sent to UCLA  
2 establishes that PacifiCare responded to each of these 2,405 claim lines. Given the requirement  
3 that insurers maintain complete claim files, I would expect that PacifiCare could produce further  
4 evidence that it had responded to these claims if it had in fact done so.

5 Under the totality of circumstances, I do not believe PacifiCare exhibited a good  
6 faith attempt to comply with these Regulations. (Reg. § 2695.12, subd. (a)(12).) Though  
7 PacifiCare eventually processed these claims, it did so only after UCLA brought these  
8 unresponded-to claims to the company's attention, only after initially rejecting UCLA's  
9 November 2009 request, only after UCLA brought these issues to the Department's attention,  
10 and only after Mr. Rossie testified at the hearing about these issues. When it first received  
11 UCLA's request in November 2009 to process these unresponded-to claims, PacifiCare claimed  
12 to be unable to do so. But then, after UCLA brought these issues to the Department, and after  
13 Mr. Rossie testified at the hearing, PacifiCare was suddenly able to process those claims without  
14 any additional information from UCLA. This is evidence of bad faith.

15 Based on my experience, failing to respond to 2,405 PPO claim lines over the  
16 course of about one year and five months reflects a high frequency. (Reg. § 2695.12,  
17 subd. (a)(12).) In general, responding to a claim is a simple task that insurers should rarely, if  
18 ever, fail to do. I have not seen evidence that the detriment to the public was severe, so I will  
19 assume that it was not, and will count this as a slightly mitigating factor.

20 UCLA informed PacifiCare about these unresponded-to claims in November 2009,  
21 but PacifiCare refused to process these claims and did not seek to remediate these errors until  
22 sometime in 2010 after Mr. Rossie testified. (Reg. § 2695.12, subd. (a)(13).) In fact, these  
23 unresponded-to claims were for dates of service as far back as March 2008. This is an  
24 aggravating factor.

25 On balance, I find that these factors represent a set of circumstances that are  
26 aggravating, as compared to the generic violation for failing to respond to claims. I therefore  
27 think it appropriate to increase the penalty by 20%, from \$2,500 to \$3,000 per act in violation.  
28

1 Therefore, my recommended aggregate penalty for this category is \$7,215,000, for these 2,405  
2 violations.

3 **Q. Does the fact that the acts in violation in this category are claim lines instead  
4 of entire claims have any effect on your penalty recommendation?**

5 A. No. A “single act” for purposes of determining a penalty pursuant to section  
6 790.035 is “any commission or omission which in and of itself constitutes a violation of  
7 California Insurance Code Section 790.03 or this subchapter.” (Reg. § 2695.2, subd. (v).) Since  
8 the facts reflect that UCLA submitted a claim for each claim line, each claim line is considered a  
9 separate claim, and therefore each claim line that PacifiCare failed to respond to constitutes an  
10 omission that constitutes a violation of section 790.03 and the Regulations, as discussed above.

11 **H. PacifiCare’s Failure to Correctly Pay Claims Other Than UCSF and  
12 UCLA Claims**

13 **Q. Are you aware of the allegations that PacifiCare failed to correctly pay  
14 claims to claimants other than UCSF and UCLA?**

15 A. Yes.

16 **Q. Do incorrect claim payments violate sections of the Insurance Code or the  
17 Fair Claims Settlement Practices Regulations?**

18 A. Yes, for the reasons I described above.

19 **Q. In general, how serious an act in violation of law do you view it when a  
20 company fails to correctly pay claims?**

21 A. I view the incorrect payment violations as being of average seriousness, for the  
22 reasons I stated above, and in general I would recommend a \$2,500 penalty for a non-willful  
23 violation of this nature, and \$5,000 for a willful act in violation.

24 **Q. Now, let me describe for you the background on these violations. Please  
25 assume the following facts:**

26 **Data supplied by PacifiCare reveal at least 78,320 claims that were  
27 incorrectly paid or denied and had to be reprocessed during the MCE period. It is likely  
28 that additional claims were improperly paid during the MCE period but reprocessed after**

1       **May 2007; the Department does not have data sufficient to determine the number of such**  
2       **claims. PacifiCare may contend that some number of these 78,320 claims were claims that**  
3       **the company previously denied or closed because it was requesting that the claimant**  
4       **submit additional information. PacifiCare, however, has failed to provide data on the**  
5       **number of these 78,320 claims it believes fall within that category. The data that**  
6       **PacifiCare has provided indicates that there were only 391 contested claims in total during**  
7       **the MCE period. As will be discussed below, that practice of denying or closing such**  
8       **claims is likewise illegal.**

9               **Many integration-related operational processes contributed to these**  
10       **incorrectly paid claims. Prior to the acquisition by United, most PacifiCare PPO claims**  
11       **processing was performed in-house. PacifiCare used a vendor called MedPlans (later**  
12       **acquired by First Source) to add back-up claim processing capacity during high-volume**  
13       **periods. Very shortly after the acquisition, PacifiCare closed its claims operations in its**  
14       **Cypress headquarter office, and laid off approximately 20 PPO claims examiners.**  
15       **PacifiCare then transferred the bulk of its PPO claims processing to MedPlans, with some**  
16       **more complex claims being processed in-house in San Antonio. United’s vendor**  
17       **management department initially took over the relationship with MedPlans, but “because**  
18       **the vendor management team didn’t really understand the PacifiCare legacy business,”**  
19       **oversight was eventually restored to PacifiCare’s claims department. In October 2006,**  
20       **PacifiCare noted that the quality of MedPlans work was “cause for termination.”**  
21       **PacifiCare continued to be frustrated with MedPlans’ poor performance in early 2007,**  
22       **noting that the “same conversations have been had over the past two or three years and if**  
23       **fixes are not made, [PacifiCare] will have to bring it back in house.” PacifiCare’s in-house**  
24       **staff had better performance than MedPlans even while processing more complex claims,**  
25       **but after the acquisition, PacifiCare began transferring even the “very complex” claims to**  
26       **MedPlans in anticipation of migrating off of the RIMS system, and by 2007, the company**  
27       **was absolutely dependent on MedPlans for PPO claims processing. As mentioned above,**  
28       **PacifiCare was aware that the piece-rate payment structure created an incentive for**

1 **MedPlans staff not to thoroughly investigate claims, and this financial model was modified**  
2 **with quality bonuses but the piece-rate compensation remained in place.**

3 **Ms. Vonderhaar testified that MedPlans was among the few vendors with**  
4 **experience processing claims on RIMS. She further testified that PacifiCare required**  
5 **MedPlans to train its staff but was unsure whether they were trained in the Fair Claims**  
6 **Settlement Practices Regulations in 2007. PacifiCare contends that MedPlans performance**  
7 **improved after PacifiCare revised the terms of payment, but has not provided any data to**  
8 **substantiate that assertion.**

9 **Another source of PacifiCare’s payment errors was a “data bridge,” called**  
10 **the Electronic Provider Data Exchange (EPDE), implemented in June 2006 to transfer**  
11 **provider data from a United database called NDB to PacifiCare’s claims engine, RIMS.**  
12 **During each EPDE feed, every record that has been changed since the last feed is**  
13 **transmitted to RIMS and overwrites RIMS records. Because every data transfer presents**  
14 **risk of erroneously changing thousands of records, data bridges are generally regarded as a**  
15 **temporary tool and it is unusual to use them when the user has control over both the source**  
16 **and destination databases, as PacifiCare did in this case. PacifiCare chose EPDE over two**  
17 **other feasible, though possibly more expensive, options: building a permanent “direct**  
18 **connection” between NDB and RIMS; and continuing to enter provider data into both**  
19 **RIMS and NDB separately.**

20 **Starting when it launched in June 2006, and continuing into 2008, EPDE**  
21 **corrupted provider data in RIMS, causing contracted providers to be paid as non-**  
22 **participating and vice-versa and erasing entire data fields, resulting in significant**  
23 **mispayment of claims. Remarking on one such error, Elena McFann, a United Vice**  
24 **President of Network Strategy, complained that “this is so wrong that I don’t know where**  
25 **to start . . . this provider wrote a thoroughly nasty letter to [Reed Tuckson, United’s Chief**  
26 **Medical Officer] that included reference to problems whose root cause [I] could point back**  
27 **to EPDE.” The company further failed to correct many of these data errors promptly,**  
28 **allowing them to languish for months, all the while the claims of these providers were being**

1 **incorrectly paid. Ms. McFann admitted that such delays were totally unacceptable.**  
2 **PacifiCare also failed for a significant period to maintain a tool called a crosswalk, which**  
3 **linked providers in RIMS to the proper fee schedules in NDB; as a result, providers were**  
4 **linked to the wrong fee schedule and their claims were paid incorrectly. PacifiCare**  
5 **executives agreed that the neglect of this “key operational process” was both**  
6 **“embarrassing” and “avoidable.”**

7 **Members and providers who attempted to contact PacifiCare regarding**  
8 **incorrect payments often found they “couldn’t get anybody to answer the phone” or left**  
9 **repeated messages to no avail. Internal PacifiCare employees reported receiving many**  
10 **complaints, specifically from California providers, about the poor quality of customer**  
11 **service — that customer service couldn’t assist on a high percentage of calls, or**  
12 **affirmatively gave out incorrect information. Providers testified that the time spent**  
13 **attempting to resolve underpayments detracted from patient care and caused “a lot of**  
14 **headaches” and the statutory interest they received for the claim amounts not initially paid**  
15 **was paltry in comparison to “all the time and grief” that PacifiCare’s underpayments**  
16 **caused. Moreover, providers would typically hold off on billing their patients until the**  
17 **correct payment is received from the insurer, and then receive no interest for the delayed**  
18 **compensation from patients. Inaccurate payments also harmed patients, who were**  
19 **concerned that they would end up owing more money than they had anticipated.**

20 **PacifiCare was aware from the outset of the risks inherent in the NDB-to-**  
21 **RIMS data bridge. But rather than mitigating these risks, PacifiCare’s hasty**  
22 **implementation of EPDE exacerbated them. PacifiCare did not identify and analyze the**  
23 **many structural differences between the data in RIMS and the data in NDB and how these**  
24 **differences would affect the flow of data; PacifiCare failed to adequately test the EPDE**  
25 **process before implementing it; and PacifiCare implemented EPDE with such minimal**  
26 **training that the EPDE team itself did not understand the basics of how the process**  
27 **worked.**

1           **Although PacifiCare was aware that EPDE was corrupting provider data,**  
2 **the company failed to put in place adequate reconciliation and quality control processes to**  
3 **detect and quickly fix the errors they knew EPDE was causing, instead relying on the**  
4 **provider community to discover issues. The reconciliation reports it did create were**  
5 **incomplete and often not monitored. Ms. McFann acknowledged that the root causes of**  
6 **some of the fee schedule errors were poor controls and employee performance. The**  
7 **company also identified the lack of audit steps on fee schedules and disparate ownership of**  
8 **fee schedules as other root causes of these errors.**

9           **PacifiCare began to fix some of the flawed EPDE program logic in April**  
10 **2007, but many other design flaws were not addressed until December 2007, and still others**  
11 **not until 2008. Although the insufficiency of quality controls was noted in late 2006 and**  
12 **again in April 2007, and PacifiCare launched a pilot project to verify provider data in**  
13 **Spring 2007, the company did not implement comprehensive quality controls and data**  
14 **reconciliation efforts until September 2007. Internal memoranda suggest that even these**  
15 **controls were not adequate. PacifiCare has acknowledged that the need for these**  
16 **reconciliation and reporting mechanisms was foreseeable in June 2006, and that many**  
17 **claims errors could have been avoided if they had been implemented earlier.**

18           **Another source of incorrect payments — this one specifically to providers —**  
19 **was the company’s failure to timely load newly executed provider contracts, in some**  
20 **instances up to 9 months after the provider signed and sent in the contract. This occurred**  
21 **throughout 2006 and 2007. PacifiCare admitted that some of these provider contracts were**  
22 **loaded after the contract’s effective date due to the company’s error. It contends that one**  
23 **of the causes of the delay was that certain of the contracts had non-standard fee schedules,**  
24 **which take time and effort to build and load. Another cause, according to the company,**  
25 **was that it received more contracts than expected. Ms. Berkel reported that the teams**  
26 **responsible for uploading provider contracts had triple the work load and the same**  
27 **number of staff. PacifiCare admits that these late-loaded contracts caused it to incorrectly**  
28 **process claims, but contends that it ultimately reworked all the incorrectly paid claims.**

1           PacifiCare further contends that some of these contracts were loaded after  
2 the effective date of the contract because of the providers' errors. Ms. McFann, for  
3 instance, testified that the company couldn't execute and upload 40% of the contracts they  
4 received during the CTN transition because the provider hadn't executed it properly. Ms.  
5 McFann believed that in those instances, the company would contact the provider to  
6 attempt to resolve the issue. The provider would then have to send in another executed  
7 version of the contract to be uploaded.

8           PacifiCare also contends that in some of the contract negotiations, it offered  
9 providers retroactive effective dates — that is, the contract had an effective date that  
10 preceded the date the contract was executed — if the providers agreed to hold their claims  
11 until the contract was actually loaded. But according to PacifiCare, providers didn't hold  
12 their claims as they had promised.

13           In examining these late contract loading issues during the MCE, CDI  
14 identified 14 providers with approximately 500 claims and billed charges of approximately  
15 \$96,000 that may have required rework. CDI required PacifiCare to review and, if  
16 necessary, readjudicate those claims. PacifiCare reported to CDI that it had implemented  
17 corrective actions to identify affected physicians and affected claims — that is, claims that  
18 were initially adjudicated before the contract was loaded for providers who had contracts  
19 loaded more than 30 days after the contract effective date — and then rework those claims.  
20 PacifiCare ultimately admitted that it had incorrectly processed 3,700 claims because of  
21 retro-loaded contracts or other issues associated with the CTN transition. According to  
22 PacifiCare, these rework claims affected approximately 1,600 providers and resulted in an  
23 additional payment of around \$200,000 to \$250,000. These 3,700 claims that PacifiCare  
24 has admitted were incorrectly processed on initial adjudication are likely in addition to the  
25 78,320 incorrectly processed claims that CDI detected from PacifiCare's data. However,  
26 because CDI does not have sufficient data on those 3,700 incorrectly processed claims to  
27 confirm that they constitute separate acts in violation, the Department has conservatively  
28 assumed that those 3,700 claims are included in the 78,320 number.

1           **Internal documents from early 2007, however, reflect PacifiCare’s estimates**  
2 **that it had to rework approximately 38,000 claims in RIMS, affecting 1,774 providers, as a**  
3 **result of the retro-loaded contracts. The company further estimated at that time that it**  
4 **had to rework 23,619 claims in RIMS, affecting 1,718 providers, as a result of fee schedule**  
5 **issues. PacifiCare contends that these figures do not reflect the number of claims that were**  
6 **reworked and required additional payment. PacifiCare also admitted to CDI that there**  
7 **were 5,486 unique MPINs, across 2,502 unique TINs that were affected by the late-contract**  
8 **uploading. “Contract loading control weaknesses” persisted through 2008.**

9           **As previously discussed, PacifiCare contends that many of its claim payment**  
10 **issues were caused by United’s loss of the CTN network, which PacifiCare asserts was a**  
11 **one-time event. When Blue Shield terminated the CTN lease agreement, the company**  
12 **contends it was forced to recontract with thousands of United providers, which the**  
13 **company contended was a tremendous undertaking. But as previously discussed, the CTN**  
14 **should have had, by PacifiCare’s own admission, only nominal impact on PLHIC.**  
15 **PacifiCare members did not lose access to their providers as a result of the CTN**  
16 **termination. Nevertheless, because of United’s haste to move PacifiCare providers onto**  
17 **United contracts and because of the new EPDE process the company implemented,**  
18 **thousands of PacifiCare PPO claims were incorrectly paid as a result of United actions it**  
19 **attributed to the CTN transition.**

20           **PacifiCare witness Ms. McFann initially testified that during the CTN**  
21 **transition the company was focused on recontracting providers who were serving United**  
22 **members, and was not attempting to recontract with PacifiCare providers unless those**  
23 **providers had terminated their contracts or unless there was an impediment to access, such**  
24 **as a contractual provision that prevented PacifiCare members from accessing a provider as**  
25 **an in-network provider. But when shown multiple letters sent in 2006 and 2007 from her**  
26 **own department, several she acknowledged she drafted, to PacifiCare providers seeking to**  
27 **recontract them onto United contracts, Ms. McFann admitted that the company was**  
28 **engaged in some contracting efforts with certain PacifiCare providers. Some of those**

1 letters informed PacifiCare providers that the company itself was terminating the  
2 PacifiCare contract and offering them United contracts to sign. Then, if those providers  
3 didn't sign United contracts, the company would send letters to patients informing them  
4 that their provider may no longer be in-network. United's going-in position documents in  
5 January 2006 reflected its plan to recontract all PacifiCare providers onto United contracts  
6 by August 2006.

7 PacifiCare has also vastly overstated the number of providers it needed to  
8 contract with during the CTN transition. And while United/PacifiCare has represented  
9 that the timing of the CTN transition was unexpected and outside of the company's control,  
10 in 2005, United/PacifiCare actually expected the lease to be terminated in June 2006 and at  
11 one point considered canceling the lease even earlier, in April 2006.

12 Moreover, PacifiCare's expert, Rick McNabb, agreed that CTN did not  
13 render EPDE "compulsory" but merely made June 2006 a convenient time to transition to  
14 a "single source of truth" for provider data. PacifiCare appears to have primarily viewed  
15 EDPE as an opportunity to reduce costs. PacifiCare executives have also acknowledged  
16 that many, if not most, of the problems with inaccurate claims payment were independent  
17 of any processes brought on by CTN.

18 PacifiCare also contends that PacifiCare members benefited from the CTN  
19 transition, because United's recontracting efforts resulted in an increase of 9,000 in-  
20 network providers for PacifiCare members.

21 PacifiCare also contends that it was following industry "best practices" by  
22 using EPDE to move to a single source of truth for California provider data. This "best  
23 practice" was not, however, applied across the board: PacifiCare chose to initially  
24 implement EPDE only for California. A few months after PacifiCare launched EPDE in  
25 California, the company sought to expand it to other states, but decided to postpone the  
26 expansion due to massive data corruption problems, while nonetheless keeping EPDE in  
27 place in California.

1                   PacifiCare also asserts that their overall claims payment accuracy was  
2 excellent. PacifiCare uses a metric known as Claim Payment Accuracy (CPA) that  
3 purports to measure the percentage of claims that were accurately paid. According to  
4 PacifiCare’s data, the company’s monthly performance on this metric ranged between  
5 89% and 97% between February 2006 and December 2007. PacifiCare claims that its  
6 performance on the Underpayment Claim Payment Accuracy (UCPA) metric, which  
7 purports to measure the percentage of claims without an underpayment error, ranged  
8 from 97.3% to 98.5% on a yearly basis from 2006 to 2009. These accuracy metrics,  
9 however, have significant flaws that undermine their utility; even consultants to the  
10 company identified flaws in them. For example, claims that were initially underpaid and  
11 only fully reimbursed after subsequent appeal and reprocessing are counted as though they  
12 were accurately paid. The reported UCPA and CPA numbers also included categories of  
13 claims, such as pharmacy benefit and auto-adjudicated claims, that were far less likely to  
14 have errors, thereby inflating the reported accuracy.

15                   PacifiCare contends that the number of alleged violations for incorrectly  
16 paid claims is high only because the Department employed tools expected to detect a high  
17 percentage of the errors in PacifiCare’s paid claims. PacifiCare contends that the  
18 Department has never before performed such a review of an insurer’s entire claims  
19 population.

20                   PacifiCare has represented in this hearing that it experienced provider data  
21 challenges before the merger; that it is impossible to fully eradicate provider data errors  
22 and that providers should take more responsibility for updating PacifiCare on  
23 demographic data; and that EPDE was “successful” and represented a “quality outcome.”  
24 At the time, however, PacifiCare referred to EPDE as a “nightmare” that resulted in  
25 “awful, frustrating” instances of data corruption, and “significant data errors in RIMS.”  
26  
27  
28

1                   **First, given this information, were these acts knowingly committed or**  
2 **performed with such frequency as to indicate a general business practice?**

3           A.     Yes. As previously stated, insurers are charged with knowledge of the amounts  
4 they are supposed to pay and of the amounts they in fact do pay to claimants. As I have seen no  
5 evidence that that PacifiCare had a reasonable basis to be unaware of these facts, PacifiCare  
6 knowingly misrepresented pertinent facts and knowingly did not attempt in good faith to  
7 effectuate prompt, fair, and equitable settlements of these claims by incorrectly processing each  
8 of these claims. Further, I believe the rapid institution of a sweeping new data processing  
9 procedure presented an obvious risk of the kinds of errors encountered, making PacifiCare  
10 chargeable with knowledge of these likely results. PacifiCare thus knowingly failed to adopt  
11 and implement reasonable standards for the prompt investigation and processing of claims.

12           There is also sufficient evidence to establish a general business practice, namely the  
13 institution of the procedures that led to the documented errors. In addition, the frequency of the  
14 errors encountered is well above that necessary to indicate that they were the result of a general  
15 business practice.

16           **Q.     Based on the information you have been given, was the issuance, amendment,**  
17 **or servicing of the policy or endorsement inadvertent, as that term is used in section**  
18 **790.035?**

19           A.     No. PacifiCare did not inadvertently issue payment on any of the claims at issue  
20 here.

21           **Q.     Given this background information, do you classify these violations as willful**  
22 **or non-willful?**

23           A.     These inaccurate claim payments were part of a purposeful and willing failure to  
24 engage in good faith attempts to promptly and fairly pay claims. PacifiCare purposely  
25 transferred more responsibility for claims processing to a vendor whose performance was so bad  
26 that it was grounds for terminating the contract, and paid that vendor in a manner that created an  
27 incentive for sloppy adjudication. The reliance on MedPlans, along with PacifiCare's  
28 implementation of EPDE without adequate testing, training, or quality controls, reflect a willing

1 failure to adopt reasonable standards for processing claims. It is simply not reasonable to  
2 continue to permit claims to be adjudicated by a company that has shown unacceptable  
3 performance for several years. Nor is it reasonable to launch a program to change provider data,  
4 on whose accuracy appropriate claim adjudication depends, without fully understanding how  
5 that program will affect the data and instituting and maintaining rigorous quality controls to  
6 detect errors. Moreover, despite mounting evidence that EPDE was in fact resulting in improper  
7 payments, PacifiCare continued to refuse to adopt reasonable standards to correct the existing  
8 data or to prevent data corruption in the future. Finally, given the knowledge that these business  
9 practices — use of EPDE and outsourcing to MedPlans — were resulting in large numbers of  
10 mispaid claims, PacifiCare was apparently willing to continually misrepresent to claimants the  
11 amount owed to providers.

12 **Q. Given this background information, what penalty would you propose for this**  
13 **category of violations?**

14 A. First, I have seen no evidence of the existence of extraordinary circumstances  
15 (Reg. § 2695.12, subd. (a)(1)), as that term is defined in the Regulations (Reg. § 2695.2, subd.  
16 (e)). The CTN lease was terminated pursuant to an express provision of the contract that United  
17 agreed to when it initially entered into that contract. That is not a circumstance outside of the  
18 company's control. Further, the company's response to the CTN termination was also entirely  
19 within its control. The CTN termination did not require United to terminate PacifiCare  
20 contracts, so the company's decision to do so was within its control and, in fact, unrelated to the  
21 CTN termination. Nor did I see evidence that the CTN termination had a severe or material  
22 effect on PacifiCare's ability to conduct normal business operations. As I am asked to assume,  
23 PacifiCare admitted that the CTN transition had nominal impact on PLHIC. Moreover, if the  
24 CTN termination created such significant burdens on the company as PacifiCare contends, it  
25 should not have added to those burdens by terminating PacifiCare providers, thereby requiring  
26 the company to renegotiate additional contracts. That was another circumstance within the  
27 company's control.

1 I saw some evidence that certain of the claims at issue here may have been  
2 complex. (Reg. § 2695.12, subd. (a)(3).) According to the company, many of the PacifiCare  
3 provider contracts were on non-standard fee schedules. I would expect insurers, however, to be  
4 able to build and to correctly and timely load any fee schedule that they agree to. If such a fee  
5 schedule is too complex to build and load, the insurer should not agree to it. Nevertheless, I will  
6 consider this to be a slightly mitigating factor.

7 Out of the approximately 1.1 million claims reviewed by the Department, at least  
8 78,320 were paid incorrectly. This represents a fairly high relative number of mispayments.  
9 This is a slightly aggravating factor. (Reg. § 2695.12, subd. (a)(7).)

10 PacifiCare did undertake some remedial efforts with respect to some of the root  
11 causes of improper claims payment. (Reg. § 2695.12, subd. (a)(8).) In particular, I credit the  
12 company for sharing information with CDI regarding the impact of certain of the claims errors.  
13 The efforts to actually correct the problems causing claims errors, however, appeared to be  
14 inadequate. PacifiCare was aware that its vendor MedPlans was processing claims poorly, but  
15 its only solution was to revise the terms of payment. By laying off its own experienced claims  
16 workforce, PacifiCare placed itself in a position where it was absolutely dependent on this  
17 underperforming vendor, which limited the company's ability to demand quality work and  
18 limited its ability to bring work in-house. With respect to EPDE, PacifiCare took some remedial  
19 actions, but several of those actions did not appear to be particularly effective; I have been given  
20 no evidence that PacifiCare corrected all the program flaws that were causing errors in 2007.  
21 Nevertheless, I will consider this as a slightly mitigating factor.

22 For the reasons previously discussed, the existence or nonexistence of previous  
23 violations factor is inapplicable in this case. (Reg. § 2695.12, subd. (a)(9).)

24 There is evidence that these violations caused harm greater than the generic  
25 violation. (Reg. § 2695.12, subd. (a)(10).) The provider and member harm typically  
26 experienced from incorrectly paid claims was exacerbated here because PacifiCare's inability to  
27 remediate these errors effectively due to the company's poor customer service. Moreover, I  
28 agree with Ms. McFann's assessment that the company's delay in fixing the underlying problems

1 of the claims payment errors was totally unacceptable. Because PacifiCare did not resolve these  
2 payment problems promptly, providers were forced to expend significant energy seeking  
3 restoration of their contracted reimbursement rates, during which they continued to have their  
4 claims mispaid. The interest paid on outstanding amounts owed was far too small to compensate  
5 for the time spent attempting to resolve the improperly paid claims.

6 On balance, I do not believe PacifiCare made a good faith attempt to comply with  
7 the Regulations. (Reg. § 2695.12, subd. (a)(11).) First, the fact that PacifiCare allowed itself to  
8 be so dependent on an underperforming vendor to perform a function as vital as processing  
9 claims is evidence of an absence of good faith. Under the assumptions I have been given,  
10 PacifiCare knew of issues with MedPlans long before the acquisition, and even mentioned  
11 terminating that vendor because of its poor performance in October 2006. The decision to  
12 transfer *more* claims responsibility to that vendor as part of the integration was irresponsible.  
13 And, in general, where the company cuts costs in ways that it knows are likely to lead to errors,  
14 the pursuit of cost savings and maximization of profit under those circumstances represent an  
15 absence of good faith. At a minimum, PacifiCare and United should have ensured that  
16 MedPlans, some other vendor, or other staff within the company could adequately process  
17 PacifiCare's PPO claims before laying off in-house claims staff. Likewise, the implementation  
18 of EPDE with inadequate analysis, testing, training, and quality control mechanisms tells me that  
19 PacifiCare was not paying adequate attention to its claims payment obligations, or perhaps  
20 believed that the penalties for a few violations would be outweighed by cost savings. And the  
21 fact that PacifiCare delayed in remediating claims payment problems and their underlying causes  
22 is further evidence of a lack of good faith. I also considered PacifiCare's contention that in some  
23 instances, providers may have been partially responsible for some of the claims errors, but the  
24 overwhelming causes of the incorrect payments appeared to be because of the company's  
25 failures. Overall, I saw a troubling lack of proper controls to prevent or quickly detect and  
26 correct claims payment problems. For the reasons I previously stated, I consider the loss of the  
27 CTN to be irrelevant to these violations. Nor does PacifiCare's contention that it increased its  
28 network by 9,000 providers constitute good faith. That fact may or may not benefit PacifiCare

1 members, and it may or may not be an additional selling point for PacifiCare business, but it  
2 does not relate to these violations that PacifiCare committed.

3 The severity and frequency of these violations is neither a aggravating nor a  
4 mitigating factor. (Reg. § 2695.12, subd. (a)(12).) The frequency was high, but I believe that  
5 the detriment to the public was no more severe than in the generic case.

6 PacifiCare was clearly aware of facts that apprised or should have apprised them of  
7 the need to take remedial measures to prevent or address these violations. (Reg. § 2695.12,  
8 subd. (a)(13).) For example, PacifiCare knew that MedPlans was not meeting its quality  
9 expectations in claims processing before 2006, and yet transferred more claims, including  
10 complex claims, to that vendor. PacifiCare also should have foreseen that a payment scheme in  
11 which MedPlans was paid per claim would create an incentive to simply deny claims, rather than  
12 completing the diligent and thorough investigation required by law. PacifiCare also surely knew  
13 that transferring data from NDB to RIMS could result in error if it did not carefully analyze the  
14 systems and map each data field correctly. Every health insurer knows that failure to properly  
15 maintain provider data will result in claims payment errors, yet PacifiCare did not implement  
16 comprehensive data reconciliation and error reporting from the outset. When it became aware  
17 that EPDE was corrupting data, it should have immediately sought to identify all affected  
18 providers, corrected their records, and identified the root causes of the errors. Alternatively, as it  
19 did in other states, PacifiCare should not have implemented the use of EPDE until the system  
20 could be made reliable. This is an aggravating factor.

21 On balance, I find these circumstances to be aggravating, as compared to the  
22 generic violation for incorrectly processing claims. I therefore think it appropriate to increase  
23 the penalty by 20%, from \$5,000 to \$6,000 per violation.

24 **Q. So that results in 78,320 acts in violation of the law at \$6,000 per act. Are**  
25 **there any other adjustments you think are appropriate?**

26 A. Yes. For the reasons previously discussed, I think it appropriate to reduce the per  
27 violation penalty by 50% after the first 50,000 violations. However, both the harm to victims and  
28 the gain to PacifiCare attributable to each additional violation is more significant than with the

1 other categories for which I have used this approach. Therefore, although in this instance the  
2 minimum per-violation penalty is not reached, in theory I would cease reducing the penalty when  
3 the per-violation amount reaches \$250. My recommended aggregate penalty for these violations  
4 is  $50,000 \times \$6,000 + 28,320 \times \$3,000$ , or \$384,960,000, for these 78,320 acts in violation.

5 **I. PacifiCare's Failure to Timely Pay Claims**

6 **Q. Are you aware of the allegations that PacifiCare failed to timely pay claims in**  
7 **violation of law?**

8 A. Yes.

9 **Q. Do failures to timely pay claims violate the Insurance Code or the Fair**  
10 **Claims Settlement Practices Regulations?**

11 A. Yes. The failure to pay an uncontested claim constitutes a violation of Insurance  
12 Code section 10123.13, subdivision (a), as well as section 10123.147, subdivision (a), which  
13 require reimbursement "as soon as practical, but no later than 30 working days after receipt of  
14 the claim." The failure to timely pay claims, if committed knowingly or performed with such a  
15 frequency as to indicate a general business practice, constitutes a violation of Insurance Code  
16 section 790.03, subdivision (h)(2), which requires insurers to act reasonably promptly upon  
17 communications with respect to claims; section 790.03, subdivision (h)(3), which requires  
18 insurers to adopt and implement reasonable standards for prompt processing of claims; section  
19 790.03, subdivision (h)(4), which requires insurers to affirm or deny coverage within a  
20 reasonable time after receipt of claims; and section 790.03, subdivision (h)(5), which requires  
21 insurers to attempt in good faith to effectuate prompt, fair and equitable settlement of claims  
22 when liability is reasonably clear.

1           **Q. PacifiCare has contended that violations of the timely payment requirement**  
2 **of section 10123.13, subdivision (a), do not constitute violations of section 790.03. It argues**  
3 **that these violations were not cited as section 790.03 violations, but rather as violations of**  
4 **laws other than section 790.03 and the Regulations, in the market conduct examination**  
5 **reports. Does the Department consider violations of timely payment requirement of section**  
6 **10123.13, subdivision (a), to be violations of section 790.03?**

7           A. Yes. Section 10123.13, subdivision (a), is the claims standard that has been  
8 violated. Section 790.03 is the section of the Unfair Practices Act where section 10123.13,  
9 subdivision (a), most appropriately falls when determining how to charge the violation in an  
10 enforcement action. Further, Fair Claims Settlement Practices Regulations, section 2695.1,  
11 subdivision (b), allows for acts and practices not delineated in these regulations to also be  
12 considered unfair claims settlement practices and subject to California Insurance Code section  
13 790.03, subdivision (h). Section 10123.13, subdivision (a), is clearly an unfair claims practice  
14 that falls in this category.

15           **Q. Why did the Department not cite these untimely payment violations as**  
16 **section 790.03 violations in the market conduct examination reports?**

17           A. The Department's policy had previously been, when an act violated multiple  
18 statutes or regulations, to identify and cite the more specific statute or regulation. In the market  
19 conduct setting, the examiner is charged with identifying and recording non-compliant acts and  
20 specific claims standards that have been alleged to be violated. The examiner is not charged  
21 with conducting a legal analysis on what potential Unfair Practices Act violations would  
22 complement the non-compliant act or claims standard. That function is left for the Department  
23 counsel to analyze and charge if an enforcement action is initiated. So when an act or omission  
24 violated say, section 10123.13, subdivision (a), and could potentially fall within section 790.03,  
25 subdivision (h), the examiner would cite only the former. That was not intended to suggest that  
26 the act or omission did not also violate section 790.03, subdivision (h).

27           To avoid such inappropriate inferences, the Department has since changed this  
28 practice and now cites all sections that an act or omission violates. This change was made

1 specifically because PacifiCare was trying to assert in this case that the Department's policy of  
2 citing only the more specific statute meant that the Department had concluded that a certain act  
3 or omission was not also a violation of the Unfair Practices Act.

4 **Q. As a general proposition, how serious an act in violation of the law do you**  
5 **view it to be when a company fails to timely pay claims?**

6 A. In comparison to the range of violations to which section 790.035 applies, I view  
7 failing to timely pay claims as being of average seriousness. It is not, for example, as serious as  
8 a violation that, by its nature, would cause a patient to be denied medical care or that presents a  
9 serious risk of bodily injury. In some cases, where the payment is late by only a day or two, the  
10 impact might be minimal. On the other hand, the prompt payment of claims is, of course,  
11 central to the proper functioning of the health insurance system. Failing to timely pay claims  
12 can impose significant financial and administrative burdens on claimants.

13 **Q. As a general proposition, where do you place this type of violation on the**  
14 **section 790.035 spectrum from zero to either \$5,000 or \$10,000 per act in violation?**

15 A. Consistent with my description of this type of violation as being of average  
16 seriousness, I would put it at 50% of the way from zero to the maximum, or \$2,500 per act for  
17 non-willful acts and \$5,000 per act for willful acts.

18 **Q. Let me describe for you the background of these untimely-claim-payment**  
19 **violations. Please assume the following facts:**

20 **During the 2007 MCE, CDI performed an electronic analysis of PacifiCare's**  
21 **paid claims population for the review period. Because of the claims volume, however, CDI**  
22 **asked the company to self-report the number of claims paid over 45 calendar days, and**  
23 **PacifiCare produced data indicating a total of 207 claims that were paid late. CDI noted**  
24 **inconsistencies in those data, however. When CDI examined additional data on**  
25 **PacifiCare's paid claims during the MCE period, it detected tens of thousands of claims**  
26 **that were paid more than 30 working days after receipt. CDI's electronic analysis did not**  
27 **attempt to determine whether the amounts paid on any of these claims were accurate.**  
28 **After CDI informed PacifiCare of these findings, PacifiCare acknowledged that it paid**

1 42,137 claims more than 30 working days after receipt. Based on those admissions, the  
2 Department cited PacifiCare for 42,137 acts in violation of the late-paid claims statute.  
3 PacifiCare produced new data at the hearing that revealed that the Department mistakenly  
4 alleged, and PacifiCare mistakenly admitted to, 3,570 of the cited late-paid claims.  
5 PacifiCare's new data also reflected that of the originally alleged 42,137 violations, 3,132  
6 were claims that PacifiCare overpaid, 452 were contested claims, and 49 were claims paid  
7 under self-directed accounts that PacifiCare contends are not subject to the time  
8 requirements of section 10123.13, subdivision (a). In addition, PacifiCare contends that of  
9 the original 42,137 late-paid claims, 5,921 claims should be excluded because, even though  
10 they were processed more than 30 working days after receipt, PacifiCare did not owe any  
11 reimbursement on them — for example, because the entire amount owed was applied to the  
12 member's deductible. CDI considers these 5,921 claims to be untimely claims. In total,  
13 CDI now alleges 34,934 acts in violation based on its review of PacifiCare's claims data  
14 during the MCE period. Tens of thousands of these claims were paid more than a month  
15 after the 30-working-day period had elapsed.

16 In investigating member and provider complaints filed against PacifiCare,  
17 CDI also identified 63 additional instances outside of the MCE period in which PacifiCare  
18 failed to timely process claims.

19 One such member complainant testified that he mailed a claim for two eye  
20 surgeries, each costing \$1,400, in July and August 2006. He received no acknowledgement,  
21 so he faxed the claim three separate times, because he believed it was “apparently lost or  
22 misfiled.” He called daily in August of 2006, but the line was busy, not answered, or he was  
23 placed on hold. One claim was inappropriately denied for four different reasons before it  
24 was paid in December 2006, and the other was never paid. He was paid \$22.60 in interest,  
25 but incurred far greater costs in getting the claim paid: time spent faxing documents and  
26 calling PacifiCare at the same time that he was attempting to start a new company,  
27 payment for fax transmissions, interest he paid to his credit card company while awaiting  
28

1 reimbursement for the claim. He and his wife also experienced significant frustration at  
2 the delay in claims payment.

3 Another member testified that she had to pay a provider \$500 out of pocket  
4 to ensure that her son would receive a time-sensitive treatment by a provider who was  
5 unwilling to provide treatment because PacifiCare had not timely paid \$1,500 in claims  
6 from prior treatments. This member was balance-billed by a different provider when  
7 PacifiCare did not remit payment within ninety days.

8 A provider also testified about his frustrating experience with PacifiCare  
9 getting a claim paid. In total, it took approximately six months for PacifiCare to pay the  
10 claim, imposing significant burdens on him and his office in “making phone calls, drafting  
11 letters, researching claims ... my staffs time, my review to decide what action to take ... the  
12 overhead costs are extremely burdensome.” He also testified to “interfere[nce] with the  
13 physician/patient relationship when I have to go bill a patient for copayment six, nine,  
14 twelve months after service is rendered.” He described his experience with PacifiCare as  
15 “sheer unadulterated frustration.”

16 Several integration-related operational deficiencies contributed to late-paid  
17 claims. First, in June 2006, PacifiCare outsourced the handling of paper claims, which  
18 constituted 45% of PLHIC’s claim volume, to Lason. PacifiCare did not give Lason proper  
19 instructions for keying claims into the claims platform and did not give Lason access to  
20 adequate systems that were necessary to identify whether a claim should be keyed into the  
21 HMO or PPO platform. Approximately 30% of PacifiCare paper claims fell out of the  
22 auto-adjudication process into error queues because the claim system did not recognize the  
23 member, and “the assumption would have been the member was not eligible when, in fact,  
24 they could have been on another system.” Approximately 1,500 PacifiCare claims “looped”  
25 between the HMO and PPO platforms each day, sometimes looping eight or nine times  
26 before getting to the right platform to be adjudicated. In late 2007, PacifiCare  
27 acknowledged that eligibility matching problems were causing late-paid claims and that it  
28 was “imperative” to give Lason a tool to fix these problems. However, that solution, which

1 cost \$65,000 to implement, met “resistance” and was not implemented until many months  
2 later, in May 2008.

3 PacifiCare also identified the document-routing problems that followed the  
4 transition to Lason, discussed above, as contributing to a 24% slowdown in claims  
5 processing as of June 2007, compared with the prior year, and to violations of the timely  
6 payment laws.

7 In March 2007, CDI asked PacifiCare to include Lason issues in its  
8 corrective action plan. By the time of a conference United convened in March 2008 within  
9 the organization, called the “Front End Deep Dive,” California regulators had been urging  
10 PacifiCare to address DocDNA misrouting and Lason-related claim processing delays for  
11 an entire year. For example, PacifiCare promised to “completely update” its policies on  
12 correspondence routing by mid-December 2007, but did not do so until May 2008. Internal  
13 emails show that PacifiCare and United staff were very frustrated with Lason problems,  
14 yet Ms. Berkel testified that the Lason implementation was “a success,” that “the vast  
15 majority of things worked well with Lason,” and they only had “routine issues” of the kind  
16 that arise “all the time.” Kelly Vavra, PacifiCare Vice President of Vendor Management,  
17 also testified that Lason “performed very well” and that she was “very proud” of Lason’s  
18 performance in 2006 and 2007.

19 PacifiCare’s transition to the United Front End (UFE) system for claims  
20 received electronically also contributed to claims processing delays. Beginning in  
21 October 2006, claims submitted through electronic data interchange (EDI) were routed  
22 from UFE to a PacifiCare gateway, and then to a claims engine. UFE had less stringent  
23 acceptance criteria than the PacifiCare’s gateway, so thousands of claims were received by  
24 UFE but rejected by the gateway. These claims simply “sat in a file” unattended and  
25 remained “lost,” in some cases for months. In one episode, EDI claims were lost in this  
26 process sometime in the fourth quarter of 2006, but not found until the first and second  
27 quarters of 2007. This issue delayed processing of a significant percent of electronic claims  
28 and contributed to claims slowdown into August 2007. Though PacifiCare was aware that

1 UFE and the PacifiCare gateway had different acceptance criteria, pre-implementation  
2 testing did not detect that these problems would occur. Further, PacifiCare did not initially  
3 establish monitoring or reconciliation controls that would have detected if claims went  
4 missing in this process; a simple claims-in, claims-out count would have likely been  
5 sufficient to have quickly detected this problem and allowed PacifiCare to locate the claims  
6 and get them timely processed. In March 2007, an automated audit system costing \$80,000  
7 was proposed but rejected as too costly; a manual audit was put in place instead. As late as  
8 July 2007, PacifiCare employees were still complaining of frequent problems with UFE's  
9 processing of EDI claims.

10 The corruption of provider demographic data by EPDE, mentioned above,  
11 also contributed to late-paid claims. Because PacifiCare and United failed to conduct a full  
12 inventory of structural differences between RIMS and NDB, the creators of EPDE failed to  
13 account for the different ways the systems stored provider billing addresses. The EPDE  
14 feed reactivated outdated addresses in RIMS, and provider checks were often sent to these  
15 old addresses and then returned to PacifiCare. By the time these claim payment checks  
16 were sent to the providers' correct addresses, more than 30 working days had elapsed.  
17 Over 1,000 California providers had address errors serious enough to result in returned  
18 checks.

19 PacifiCare was aware of these problems for months before seeking to  
20 implement remedial actions. Immediately after EPDE was implemented in June 2006,  
21 providers began complaining that their reimbursement checks were suddenly being sent to  
22 outdated addresses. In November 2006, a PacifiCare employee reported multiple instances  
23 in which providers' billing suffixes were corrupted in RIMS and suggested that a report be  
24 run to identify all the billing addresses similarly affected. A month later, PacifiCare  
25 observed that NDB's overlay of RIMS data had created "a huge mess" and that "a lot of  
26 our RIMS providers have been paid ... to wrong addresses." In January 2007, 11,000  
27 RIMS records were changed to new billing addresses. Yet a member of the EPDE team  
28 tasked with identifying required remedial actions decided that no review of the changed

1 records was necessary: “NDB is the source of truth for CA PPO. So regardless of what was  
2 in RIMS before, it’s good now.” PacifiCare did not discover the primary cause for  
3 returned checks until April 2007. Even still, other EPDE errors continued to affect  
4 provider addresses into 2008. Identification of the root cause was “hampered by lack of  
5 trail of changes between NDB and PHS engines.”

6 PacifiCare’s layoffs of experienced claims staff likely contributed to the  
7 delays in processing claims. Included among late-paid claims are claims that were initially  
8 improperly denied. CDI complaint investigations discovered instances in which PacifiCare  
9 reworked such claims several months after the initial denial. Following the layoffs of  
10 Cypress staff, there were “limited rework claims examiners” and PacifiCare had to rehire  
11 some of its laid-off employees through a temp agency.

12 PacifiCare contends that all insurers face some level of provider data  
13 inaccuracy, so returned checks can never be fully eliminated. The company points out that  
14 there were fewer returned checks on average in 2007 than in 2006, though this decrease  
15 coincides with a reduction in PacifiCare PPO membership and came after PacifiCare had  
16 at least partially remediated errors in provider demographic data. Ms. Vonderhaar, also  
17 testified that during the market conduct period PacifiCare consistently met its internal  
18 turnaround-time metrics for claims, which was to process 95% of claims within 20 business  
19 days. Ms. Vonderhaar acknowledged that they had more late paid claims than usual  
20 during this period, but she said she was untroubled by the operational deficiencies that  
21 delayed claim processing as long as the internal metrics were satisfied. PacifiCare also  
22 believes that the number of alleged violations for late-paid claims is high only because the  
23 Department performed a review of 100% of PacifiCare’s paid claims. PacifiCare contends  
24 that the Department has never before performed such a review of an insurer’s entire  
25 claims population.

26 Further, in calculating the number of claims that PacifiCare paid late, more  
27 than 30 working days after receipt, CDI considered untimely claims that were paid more  
28 than 42 calendar days after receipt. One CDI examiner, Derek Washington, testified that a

1 45 calendar day standard is generally used in market conduct. Another CDI employee,  
2 Towanda David, testified that the Department uses both 42 and 45 calendar day standards,  
3 depending on how the company being examined counts working days. For the PacifiCare  
4 examination, the Department initially used a 45 calendar day standard, but then changed  
5 to a 42 calendar day standard because that was the standard used internally by PacifiCare.  
6 PacifiCare did not dispute the 42 day standard when it was applied in the market conduct  
7 exam. Based on PacifiCare's calculations the change to a 42 calendar standard increased  
8 the number of alleged violations by approximately 2,000.

9 In your view, should the claims that were paid after more than 42 but less  
10 than 45 working days be penalized?

11 A. Yes. First, section 10123.13, subdivision (a), requires that claims be reimbursed  
12 "as soon as practical, but no later than 30 working days after receipt of the claim." (Emphasis  
13 added.) Therefore, the law requires claims to be reimbursed even sooner than 30 working days,  
14 if practical. In general, however, the Department applies the 30 working day standard by  
15 ascertaining how many days per month constitute "working days" for that particular insurer. If  
16 PacifiCare accepted the use of a 42 calendar day standard during the MCE, CDI would use that  
17 standard as the measure for 30 working days.

18 Q. PacifiCare contends that these violations for late-paid claims do not reflect a  
19 general business practice because PacifiCare timely paid over 96% of claims during that  
20 period. PacifiCare also contends that the 2009 NAIC Market Regulation Handbook, which  
21 PacifiCare argues CDI is required to observe (citing Ins. Code, § 733, subd. (f)), strongly  
22 encourages regulators to use a 7% tolerance level for evaluating when violations of the  
23 state's unfair claim and trade practices have occurred. PacifiCare also claims that it  
24 should not be penalized for late-paid claims because it satisfied the "Claims processed  
25 within 30 calendar day" metric set forth in Undertaking 19."

1           **In light of these contentions, and if in fact PacifiCare timely paid 96% of its claims**  
2 **timely, can the failure to pay these 34,997 claims constitute a general business practice**  
3 **punishable under section 790.035?**

4           A.     Yes. CDI conducts market conduct examinations under the “report by exception”  
5 method. The Department investigates and cites insurers for acts in violation of law, not the  
6 percentage of violations out of the total universe of claims. In fact, it would be impossible to  
7 calculate such a percentage because the Department does not make findings about the number of  
8 compliant acts. The Foreword of each MCE report states:

9                     “The report is written in a ‘report by exception’ format. The  
10 report does not present a comprehensive overview of the subject insurer’s  
11 practices. The report contains a summary of pertinent information about  
12 the lines of business examined, details of the non-compliant or  
13 problematic activities that were discovered during the course of the  
14 examination and the insurer’s proposals for correcting the deficiencies.  
15 When a violation that resulted in an underpayment to the claimant is  
16 discovered and the insurer corrects the underpayment, the additional  
17 amount paid is identified as a recovery in this report. All unacceptable or  
18 non-compliant activities may not have been discovered. Failure to  
19 identify, comment upon or criticize non-compliant practices in this state  
20 or other jurisdictions does not constitute acceptance of such practices.”

21                     CDI does not, and is not required to, follow the NAIC Market Regulation  
22 Handbook. Moreover, the version of the NAIC Market Regulation Handbook that was in effect  
23 during the MCE period, and during the time PacifiCare was committing the acts in violation,  
24 says nothing about using a 7% threshold level to establish whether violations of the state’s unfair  
25 claim and trade practices have occurred. Even the 2009 version states only that error rates in  
26 excess of 7% are presumed to be unfair business practices, and does not state that error rates  
27 *below* 7% are presumed *not* to be.

28                     In addition, the absolute number or percentage of acts in violation, in isolation, is  
not determinative of whether a business practice exists; CDI examines the context of the  
violations as well as their total number. Indeed, a single act may be a violation of  
section 790.03, subdivision (h), if it is committed with actual, implied, or constructive  
knowledge. (10 C.C.R. § 2695.2(1).)

1           Furthermore, in this case several business practices contributing to the violations  
2 were identified by PacifiCare itself. I would not expect there to be any dispute that, for example,  
3 the outsourcing to Lason and the institution of EPDE and the United Front End represent  
4 business practices, and that the manner in which they were implemented are part of those  
5 business practices.

6           Compliance with the Undertakings does not preclude imposition of a penalty for  
7 violations of the law relating to the timely payment of claims. Undertakings are commitments by  
8 insurers to maintain their own claim performance (measured based on the company's historical  
9 performance), and to submit voluntary reports on that performance, independent of obligations  
10 imposed by law.

11           **Q. PacifiCare also argues that Insurance Code section 10123.13, subdivision (b),**  
12 **which requires payment of 10% interest on claims paid more than 30 working days after**  
13 **receipt, is the exclusive penalty for late-paid claims. Do you agree?**

14           A. No. The legal requirements to timely pay a claim and to pay interest on late-paid  
15 claims are separate obligations. PacifiCare's interpretation would permit insurers to purposely  
16 pay any claim late, as long as it is willing to pay 10% interest. In fact, during periods when the  
17 rate of return is higher than 10%, it would be profitable for insurers to pay claims late. Such an  
18 interpretation would undermine the objectives of the Insurance Code. Furthermore, it will not  
19 always be the case that 10% interest fully compensates the claimant for the time-value of  
20 money. As the testimony of the patient with the eye-surgery claim shows, sometimes a late  
21 payment causes the claimant to incur credit card charges, which will usually be assessed interest  
22 at a rate in excess of 10%.

23           **Q. Given this information, were these acts knowingly committed or performed**  
24 **with such frequency as to indicate a general business practice?**

25           A. Yes, these acts were knowingly committed. PacifiCare is charged with  
26 constructive knowledge of when it receives claims and when it pays claims. Absent evidence  
27 that PacifiCare had a reasonable basis to be unaware of when it received certain claims and when  
28 it paid claims, PacifiCare knowingly paid these claims late, and therefore knowingly failed to

1 acknowledge and act reasonably promptly and knowingly failed to affirm or deny coverage  
2 within a reasonable time.

3 In addition, many of these violations occurred after PacifiCare had actual  
4 knowledge that the systems contributing to the violations were deficient. PacifiCare is further  
5 chargeable with knowledge of the likely consequences of implementing these systems in the  
6 hasty and slipshod manner in which they were implemented. Additionally, the tens of thousands  
7 of late-paid claims represents a frequency well in excess of the number necessary to support an  
8 inference of a general business practice, an inference that is not necessary in any event because  
9 the business practices themselves are known.

10 **Q. Based on the information you have been given, was the issuance, amendment,**  
11 **or servicing of the policy or endorsement inadvertent, as that term is used in section**  
12 **790.035?**

13 A. No. PacifiCare did not inadvertently issue payment on any of these claims.

14 **Q. Given the background information on these violations, do you classify them**  
15 **as willful or non-willful?**

16 A. These are willful acts in violation of the law. PacifiCare continued to willingly  
17 utilize business processes that it knew were causing it to not affirm or deny coverage within a  
18 reasonable time. PacifiCare observed a 24% slowdown in claims processing and yet did not  
19 address the root causes for months. A company that pays tens of thousands of claims over a  
20 month late is clearly willingly failing to effectuate prompt payment of claims. Moreover,  
21 PacifiCare recklessly designed new processes, including UFE, Lason's correspondence routing  
22 and claim data entry processes, and EPDE in a manner that made claims processing errors highly  
23 foreseeable; failed to equip these processes with appropriate quality control mechanisms, and  
24 failed to promptly investigate and address the resulting problems. These acts represent a willful  
25 failure to adopt reasonable claims processing standards.

1           **Q.     Now, in light of the facts you have been asked to assume and the factors**  
2 **enumerated in section 2695.12, what penalty would you propose for this category of alleged**  
3 **violations?**

4           First, I have seen no evidence of the existence of extraordinary circumstances  
5 (Reg. § 2695.12, subd. (a)(1)), as that term is defined in the Regulations (Reg. § 2695.2,  
6 subd. (e)). The general difficulty in maintaining provider data is not an extraordinary  
7 circumstance. Nor is the fact that CDI performed an electronic analysis of all PacifiCare’s paid  
8 claims during the MCE period. That analysis did not cause PacifiCare to commit these  
9 violations; it only aided CDI in detecting them.

10           I also did not see evidence that these claims were on the whole more complex  
11 than the average claim. (Reg. § 2695.12, subd. (a)(3).) The difficulty in maintaining provider  
12 data is something that applies to every provider claim, and an issue that every insurer must  
13 manage. I saw nothing that indicated that this issue was any greater or less complex for  
14 PacifiCare.

15           The relative number of claims where the noncomplying acts were found to exist is a  
16 slightly mitigating factor. (Reg. § 2695.12, subd. (a)(7).) During the MCE period, PacifiCare  
17 failed to pay timely pay claims in 34,934 instances. The Department reviewed 1,126,107 claims  
18 during this period. However, sections 10123.13 and 10123.147 require reimbursement “as soon  
19 as practical but no later than 30 working days after receipt.” While only 34,934 claims were  
20 reimbursed after the statutory cut-off on which interest begins to accrue, PacifiCare’s business  
21 practices caused many more claims to not be paid “as soon as practical.”

22           PacifiCare did undertake remedial actions with respect to these violations. (Reg. §  
23 2695.12, subd. (a)(8).) I credit the corrective actions PacifiCare implemented with respect to  
24 EPDE and Lason, even though those actions could and should have been put into place much  
25 earlier. PacifiCare appears to have assured CDI that corrective actions were underway, but only  
26 implemented them much later. This is a slightly mitigating factor.

27           For the reasons previously discussed, the existence or nonexistence of previous  
28 violations factor is inapplicable in this case. (Reg. § 2695.12, subd. (a)(9).)

1           In this case, the harm caused by late-paid claims was exacerbated by PacifiCare's  
2 failure to promptly respond to inquiries and complaints by both providers and consumers. (Reg.  
3 § 2695.12, subd. (a)(10).) There were also many instances in which payment was extremely late.  
4 The harm caused by these violations is an aggravating factor.

5           Under the totality of circumstances, I cannot conclude that PacifiCare exhibited a  
6 good faith attempt to comply with these Regulations. (Reg. § 2695.12, subd. (a)(12).) Ms.  
7 Vonderhaar seemed very focused on meeting PacifiCare's internal claims timeliness metric,  
8 which is an indication of good faith. However, PacifiCare seemed to believe that a certain  
9 number of violations were acceptable as long as those metrics were met. PacifiCare refused to  
10 invest in appropriate testing and quality control measures, and exhibited an alarming lack of  
11 urgency in addressing issues that the company knew to be causing late-paid claims, despite  
12 assuring the Department that it was correcting these issues.

13           The frequency of late-paid claims is a slightly mitigating factor. (Reg. § 2695.12,  
14 subd. (a)(12).) While the severity of the violations was exacerbated by PacifiCare's deeply  
15 flawed customer service, I consider this factor to overall be slightly mitigating.

16           PacifiCare was clearly aware of facts that apprised or should have apprised the  
17 company of claims timeliness violations. (Reg. § 2695.12, subd. (a)(13).) For example, from  
18 the time that PacifiCare outsourced mail handling to Lason, PacifiCare knew or should have  
19 known that Lason would need adequate access to eligibility information in order to route claims  
20 to the correct platform. Any reasonable insurer would know that it was necessary to audit the  
21 number of EDI claims entering the front end and being uploaded to the claims systems. There  
22 were many warning signs that should have apprised PacifiCare that the EPDE process was  
23 causing checks to be sent to the wrong address, yet it failed to investigate those warnings.  
24 Lason's document routing problems were also foreseeable given the design of the routing  
25 system. The company's remedial measures came far too late.

26           On balance, I find that these factors represent a set of circumstances that are  
27 slightly aggravating, as compared to the generic late-pay violation. I think it appropriate to  
28

1 increase the per violation penalty by 10%, from \$5,000 to \$5,500 per act in violation. Therefore,  
2 my recommended aggregate penalty is \$192,483,500, for the 34,997 willful violations.

3 **J. PacifiCare's Failure to Pay Interest on Late-Paid Claims**

4 **Q. Are you aware of the allegations that PacifiCare failed to pay interest on late-**  
5 **paid claims in violation of law?**

6 A. Yes.

7 **Q. Do failures to pay interest on late-paid claims violate the Insurance Code or**  
8 **the Fair Claims Settlement Practices Regulations?**

9 A. Yes. The failure to pay interest on late-paid claims, if committed knowingly or  
10 performed with such a frequency as to indicate a general business practice, constitutes a  
11 violation of Insurance Code section 790.03, subdivision (h)(1), because it is a misrepresentation  
12 of a pertinent fact relating to coverage. It also violates section 790.03, subdivision (h)(3),  
13 because it reflects a failure to adopt and implement reasonable standards for the prompt  
14 investigation and processing of claims. It further violates section 790.03, subdivision (h)(5),  
15 because it reflects the insurer not attempting in good faith to effectuate prompt, fair, and  
16 equitable settlements of claims. Failing to pay interest also violates section 10123.13,  
17 subdivision (b), which requires that claims paid more than 30 working days after receipt be paid  
18 interest at a 10 percent rate.

19 **Q. As a general proposition, how serious an act in violation of the law do you**  
20 **view it to be when a company fails to pay interest on late-paid claims?**

21 A. In comparison to the range of violations to which section 790.035 applies, I view  
22 failing to pay interest on late-paid claims as less serious than the average violation. When  
23 claimants are not paid interest on late-paid claims, they are not being fully and accurately  
24 compensated what they are owed. This may have adverse financial consequences similar to  
25 those occasioned by the underpayment of a claim. Failing to pay statutorily required interest on  
26 claims may also create unnecessary administrative burdens on claimants who may be forced to  
27 track down information about particular claims they had submitted and to follow up with insurers  
28 to ensure that appropriate interest was paid.

1           **Q. As a general proposition, where do you place this type of violation on the**  
2 **section 790.035 spectrum from zero to either \$5,000 or \$10,000 per act in violation?**

3           **A. Consistent with my description of this type of violation as less serious than many**  
4 **other violations of section 790.03, I would put it at 20% of the way from zero to the maximum,**  
5 **or \$1,000 per act for non-willful acts and \$2,000 per act for willful acts.**

6           **Q. Let me describe for you the background of these failure-to-pay-interest**  
7 **violations. Please assume the following facts:**

8                   **During the 2007 MCE, CDI performed an electronic analysis of PacifiCare's**  
9 **paid claim population for the review period. That analysis uncovered thousands of claims**  
10 **that were paid more than 30 working days after receipt but contained no payment of**  
11 **interest. The electronic analysis did not attempt to determine whether any of the interest**  
12 **payments that were made were accurate. PacifiCare explained that for some of these**  
13 **claims no interest was owed because, for example, the entire allowable amount was applied**  
14 **to the deductible or the claim entries reflected claim overpayments. PacifiCare admitted,**  
15 **however, that there were 5,432 claims that were paid late without interest, and the**  
16 **Department therefore cited those as acts in violation. During the MCE, PacifiCare**  
17 **represented to the Department that the company had completed readjusting these claims**  
18 **and had made additional payments of \$138,792.65, of which \$33.65 was issued for the**  
19 **individual claims and \$138,759.00 was issued for the group claims.**

20                   **At the hearing, PacifiCare offered different figures. Ms. Berkel testified that**  
21 **there were 5,447 claims that were paid late without interest. Ms. Berkel further testified**  
22 **that, as of June 10, 2010, more than two years after the final MCE reports had been issued,**  
23 **the company had reprocessed and paid interest on only 4,634 of those claims. The**  
24 **remaining 813, which were claims that were originally paid in 2006 and 2007, were, as of**  
25 **that date, still being reprocessed, and appropriate interest had yet to be paid on them.**  
26 **Then, on August 31, 2010, Ms. Berkel testified that the company had completed its work on**  
27 **those 813 claims and determined that 561 of them required additional payment of**  
28 **\$4,049.34 for interest, which was paid between June and July 2010. In total, there were**

1 5,195 late-paid claims on which PacifiCare failed to pay statutory interest in violation of  
2 the law. Accordingly, CDI has amended its Accusation to allege 5,195 acts in violation  
3 regarding PacifiCare's failure to pay interest.

4 PacifiCare performed calculations that show that the total amount of interest  
5 that was paid on these claims was 0.0463% of the total payments PacifiCare made on all  
6 claims and that PacifiCare was 99.5% compliant with section 10123.13, comparing the  
7 number of late-paid claims with no interest to the total number of paid claims during the  
8 MCE period. Based on other PacifiCare calculations, over 50% of the interest paid on  
9 these claims was less than \$1.00, over 85% of the interest paid was \$10.00 or less, and the  
10 median interest paid per claim was \$0.87. PacifiCare also determined that of the claims  
11 PacifiCare believes were paid late during the MCE period, 23,658 were paid with interest,  
12 and 5,195 were paid without interest. Thus, the total number of claims during the MCE  
13 that required interest was 23,658 plus 5,195, or 28,853. The rate of compliance with the  
14 interest requirement would be the total number of claims that PacifiCare paid with interest  
15 (23,658) divided by the total number of claims requiring interest (28,853):

16 
$$23,658 / (23,658 + 5,195) = 82\%.^1$$

17 When Ms. Berkel was presented with this calculation and the result, she admitted that the  
18 percentage did not represent satisfactory performance by PacifiCare.

19 Ms. Berkel, testified that the reason that interest wasn't paid on these claims  
20 was that the RIMS system did not automatically calculate interest on readjudicated claims,  
21 so an examiner must manually calculate interest. Ms. Berkel therefore concluded that the  
22 root cause of these failures to pay interest was human error.

23 Ms. Berkel further testified that the company has undertaken corrective  
24 actions relating to these failures to pay interest. The company has updated its policies and  
25 procedures, has trained its claims examiners, has tested its claims examiners on that  
26 training, and has implemented weekly focused audits on late paid claims to make sure that

27 \_\_\_\_\_  
28 <sup>1</sup> This compliance measures only whether some amount of interest was paid, and not  
whether the correct amount of interest was paid.

1 interest is being paid appropriately. PacifiCare also provided its examiners on October 3,  
2 2007, an interest calculator that assists examiners in calculating interest. The company  
3 also claims to follow an “err on the side of overpayment” policy to use the earliest received  
4 date on a claim for purposes of calculating interest. PacifiCare also contends that the  
5 results of its focused audits on interest payment accuracy reflect a 95.1% accuracy rating  
6 for 2008 and a 98.1% accuracy rating for 2009.

7 **First, given this information, were these acts knowingly committed or**  
8 **performed with such frequency as to indicate a general business practice?**

9 A. Yes. PacifiCare is chargeable with knowledge of the amounts it pays on claims,  
10 including the amounts it pays in statutory interest. I have been given no evidence that  
11 PacifiCare had a reasonable basis to be unaware of these facts. Therefore, by failing to pay  
12 statutory interest on these claims, PacifiCare knowingly misrepresented pertinent facts,  
13 knowingly failed to adopt and implement reasonable standards for the prompt investigation and  
14 processing of claims, and knowingly did not attempt in good faith to effectuate prompt, fair, and  
15 equitable settlements of claims.

16 Further, PacifiCare knew or should have known that it had not provided its  
17 examiners with the tools and training necessary to correctly pay interest, making the resulting  
18 acts knowing. The inadequate tools and insufficient training are themselves business practices,  
19 and the thousands of violations represent a frequency adequate to indicate the general business  
20 practice.

21 **Q. Based on the information you have been given, was the issuance, amendment,**  
22 **or servicing of the policy or endorsement inadvertent, as that term is used in section**  
23 **790.035?**

24 A. No. I saw no evidence that PacifiCare’s failure to pay interest on these claims  
25 was an inadvertent issuance, amendment, or servicing of a policy. PacifiCare did not  
26 inadvertently pay any of the claims at issue here.

1           **Q.     Given this background information, do you classify these violations as willful**  
2 **or non-willful?**

3           A.     These are willful acts. The absence of proper interest was a knowable  
4 consequence of paying a claim late and of the willing failure to adequately train and equip its  
5 claims personnel. In failing to adequately train and equip its claims personnel, PacifiCare  
6 willfully failed to adopt and implement reasonable standards for the prompt investigation and  
7 processing of claims.

8           **Q.     Now, in light of the facts you have been asked to assume and the factors**  
9 **enumerated in section 2695.12, what penalty would you propose for this category of alleged**  
10 **violations?**

11                     First, I have seen no evidence of the existence of extraordinary  
12 circumstances (Reg. § 2695.12, subd. (a)(1)), as that term is defined in the Regulations  
13 (Reg. § 2695.2, subd. (e)).

14                     I also did not see evidence that these claims were complex, or that there was  
15 anything complex about paying interest on late-paid claims. (Reg. § 2695.12, subd. (a)(3).)

16                     The relative number of claims where the noncomplying acts were found to exist is  
17 a slightly mitigating factor. (Reg. § 2695.12, subd. (a)(7).) During the MCE period, PacifiCare  
18 failed to pay interest on late-paid claims in 5,195 instances. The Department reviewed 1,126,107  
19 claims during this period. PacifiCare apparently used these two numbers to calculate a 99.5%  
20 compliance rate. To assess PacifiCare's compliance with the interest payment requirement,  
21 however, the more appropriate measure would be to compare the total number of late-paid  
22 claims that PacifiCare paid with interest to the total number of late-paid claims on which interest  
23 was owed. That compliance rate for these claims was 82%, which I agree with Ms. Berkel is  
24 unsatisfactory.

25                     PacifiCare did undertake remedial actions with respect to these violations. (Reg.  
26 § 2695.12, subd. (a)(8).) In particular, I credit the corrective actions PacifiCare implemented,  
27 though I saw no reason any or all of those actions could not have been put into place previously.  
28 PacifiCare also reprocessed the claims at issue and made additional payments of interest. The

1 company's policy to err on the side of overpayment and to use the earliest received date of a  
2 claim for purposes of calculating interest is another remedial action I credit. This is a mitigating  
3 factor.

4 For the reasons previously discussed, the existence or nonexistence of previous  
5 violations factor is inapplicable in this case. (Reg. § 2695.12, subd. (a)(9).)

6 As discussed above, the harm from failing to pay interest may be financial and  
7 administrative. (Reg. § 2695.12, subd. (a)(10).) I considered PacifiCare's calculations that the  
8 total amount of interest that was paid on these claims represented 0.0463% of the total amount of  
9 claim payments PacifiCare made during this period, that over 50% of the reprocessed claims  
10 received interest of less than \$1.00, that over 85% of the reprocessed claims received paid  
11 interest of \$10.00 or less, and that the median interest paid per claim was \$0.87. Based on these  
12 figures, I will assume that for a majority of these claims, PacifiCare's failure to pay interest did  
13 not have serious financial consequences for providers. It is possible, however, that PacifiCare's  
14 failure to pay interest caused financial harm in some instances. In addition, the fact that the  
15 median interest paid on these claims was \$0.87 leads me to believe that claimants incurred  
16 administrative burdens greater than the amount that the interest payment compensated them for.  
17 This factor, overall, is slightly mitigating.

18 Under the totality of circumstances, I do not believe PacifiCare exhibited a good  
19 faith attempt to comply with these Regulations. (Reg. § 2695.12, subd. (a)(12).) PacifiCare did  
20 implement remedial measures regarding this violation and ultimately reprocessed and paid  
21 interest on these claims. But PacifiCare failed to reprocess and pay interest on 561 of these  
22 claims until mid-2010, years after CDI identified this problem to the company. PacifiCare also  
23 previously represented during the MCE to CDI that these claims had all been reprocessed and  
24 paid, which turned out not to be the case. These failures cause me concern. Overall, this is a  
25 slightly aggravating factor.

26 Failing to pay any interest on 5,195 late-paid claims during the period of the MCE  
27 is a medium-to-high frequency. (Reg. § 2695.12, subd. (a)(12).) However, I did not see  
28

1 evidence that the detriment to the public was particularly severe. This factor is neither  
2 mitigating nor aggravating.

3 I believe that PacifiCare management should have been aware of the failures to  
4 pay interest on these claims. (Reg. § 2695.12, subd. (a)(13).) All that was required was for  
5 PacifiCare to review its paid claim data, to identify which claims were paid late but without  
6 interest, and to reprocess those claims to determine if and how much interest was owed.  
7 PacifiCare failed to perform this analysis until CDI raised this issue with the company. Further,  
8 as discussed above, PacifiCare was cited by CDI in 2007 for failing to pay interest on these  
9 claims, but failed to reprocess 561 of these claims until 2010. This is an aggravating factor.

10 On balance, I find that these factors represent a set of circumstances that are  
11 slightly mitigating, as compared to the generic failure to pay interest violation. I think it  
12 appropriate to decrease the per violation penalty by at most 15%, from \$2,000 to \$1,700 per act  
13 in violation. Therefore, my recommended aggregate penalty for this category is \$8,831,500, for  
14 the 5,195 violations.

15 **K. PacifiCare's Failure to Acknowledge the Receipt of Claims**

16 **Q. Are you aware of the allegations that PacifiCare failed to send letters**  
17 **acknowledging the receipt of paper claims in violation of law?**

18 A. Yes.

19 **Q. Do failures to send acknowledgement letters for paper claims constitute**  
20 **violations of the Insurance Code or the Fair Claims Settlement Practices Regulations?**

21 A Yes. The failure to send acknowledgement letters for paper claims, if  
22 committed knowingly or performed with such a frequency as to indicate a general business  
23 practice, constitutes a violation of Insurance Code section 790.03, subdivision (h)(2), which  
24 requires insurers to acknowledge and act reasonably promptly upon communications with  
25 respect to claims arising under insurance policies. They are also violations of section 790.03,  
26 subdivision (h)(3), because not sending letters acknowledging the receipt of claims reflects a  
27 failure to adopt and implement reasonable standards for prompt investigation and processing of  
28 claims arising under insurance policies. They also violate section 10133.66, subdivision (c),

1 which requires insurers to acknowledge the receipt of claims in the same manner as the claim  
2 is submitted or provided. Failing to send acknowledgement letters also violates Regulation  
3 section 2695.5, subdivision (e), which requires insurers to acknowledge the receipt of claims.

4 **Q. As a general proposition, how serious an act in violation of the law do you**  
5 **view it to be when a company fails to send letters acknowledging the receipt of paper**  
6 **claims?**

7 A. In comparison to the range of violations to which section 790.035 applies, I view  
8 failing to send acknowledgement letters for paper claims as less serious than the average  
9 violation. As a general matter, it is not as serious as violations that could cause a patient to be  
10 denied medical care or as serious as violations of the duty to correctly and timely pay claims.

11 Failing to send acknowledgement letters can create administrative burdens. For  
12 instance, claimants may be forced to track down whether and when their claims were received by  
13 the insurer. Such failures also may make it difficult for claimants to determine whether the  
14 insurer paid the appropriate interest on late-paid claims. In some instances, claimants not having  
15 received confirmation that their claims were received will send in an additional copy of the  
16 claims. This practice further increases administrative burdens on both the claimant and the  
17 insurer.

18 **Q. As a general proposition, where do you place this type of violation on the**  
19 **section 790.035 spectrum from zero to either \$5,000 or \$10,000 per act in violation?**

20 Consistent with my description of this type of violation as less serious than many  
21 other violations of section 790.03, I would put it at 20% of the way from zero to the maximum,  
22 or \$1,000 per act for non-willful acts and \$2,000 per act for willful acts.

23 **Q. Let me describe for you the background of these acknowledgment violations.**  
24 **Please assume the following facts:**

25 **As you are aware, the Department investigated PacifiCare's procedures for**  
26 **acknowledging the receipt of claims during the 2007 Market Conduct Examination (MCE).**  
27 **The Department requested that PacifiCare produce data on the dates that claims were**  
28 **acknowledged during the MCE period. PacifiCare initially responded on September 20,**

1 2007, that those dates are not tracked in RIMS, have to be queried manually, and can only  
2 be provided on an individual claim basis. In other words, PacifiCare represented to CDI  
3 that acknowledgement letters were being sent during the MCE period, but the dates of the  
4 acknowledgement letters couldn't be provided on an automated basis. This representation  
5 was false: Acknowledgment letters were not being sent at any time during the MCE period.  
6 Internal PacifiCare documents showed that the company, on September 19, 2007, the day  
7 before the September 20 response, had discovered a gap in its process for sending out  
8 acknowledgment letters, but affirmatively decided not to disclose that gap to CDI, and  
9 instead simply indicated that the data were not available for reporting.

10 When CDI followed up with a referral requesting information about  
11 PacifiCare's procedures for complying with the acknowledgment statute, Insurance Code  
12 section 10133.66, subdivision (c), PacifiCare admitted on October 16, 2007, that  
13 acknowledgment letters were not being printed from July 2006 until January 2007.  
14 PacifiCare represented that the failure occurred because its vendor failed to print these  
15 letters. Having been told that acknowledgment letters were being sent beginning as of  
16 January 2007, CDI issued a referral requesting that PacifiCare produce copies of 10  
17 sample acknowledgment letters of PacifiCare's choosing. PacifiCare responded on  
18 October 25, 2007, that it was "unable to provide carbon copies of the letters at this time";  
19 instead, PacifiCare provided a sample letter recreated using its template. That sample  
20 letter purported to be an acknowledgment letter to a provider dated October 24, 2007.

21 As it turned out, provider acknowledgment letters were not being sent at that  
22 time. At the hearing, PacifiCare witnesses admitted that those letters were not being sent  
23 from January 2006, when the acknowledgment statute, section 10133.66, subdivision (c),  
24 became effective, until March 1, 2008. PacifiCare witnesses have further testified at the  
25 hearing that it had failed to send acknowledgment letters to members from August 2006  
26 until March 2007. PacifiCare has provided no explanation for the letter that it produced in  
27 October 2007 purporting to be a sample provider acknowledgment letter during a time  
28 that no such letters were being sent. In December 2007, PacifiCare again represented that

1 its acknowledgment letter process was not in compliance for July 2006 through December  
2 2006.

3 Lois Norket, a PacifiCare claims manager, testified at the hearing that  
4 acknowledgment letters were being sent beginning in February 2007:

5 “[By Mr. Strumwasser] As far as you know, were acknowledgment letters  
6 sent out in February 2007?”

7 “A. That was the understanding that I had.”

8 “Q. To the best of your knowledge, when was the issue of failure to send  
9 acknowledgment letters resolved?”

10 “MR. VELKEI: Objection, vague.

11 “THE COURT: Overruled. Do you understand?”

12 “THE WITNESS: You’re referring to actual hardcopy acknowledgment  
13 letters, correct?”

14 “MR. STRUMWASSER: Q. Yes.

15 “A. From my understanding, when this was identified as an issue, they  
16 should have started printing and being mailed in February of 2007. That’s  
17 what I was told.”

18 That testimony was false. Internal PacifiCare documents show that Ms. Norket knew in  
19 February 2008 that provider acknowledgment letters had not been sent at any time from  
20 2004 to February 2008.

21 PacifiCare has not offered any testimony about, and does not appear to have  
22 performed any analysis to determine, the root cause of its failure to send provider  
23 acknowledgment letters. Internal PacifiCare documents that CDI reviewed and introduced  
24 at the hearing indicate that PacifiCare intended to send these provider letters at least as  
25 early as 2004, but failed to do so because its claim system was set up wrong. Apparently a  
26 parameter in the RIMS setup contained an “N” instead of the “Y” that was required to  
27 generate the acknowledgment letters. No explanation was provided for why PacifiCare  
28 didn’t detect this failure for over four years. As to the member acknowledgment letters,  
PacifiCare acknowledged that its failure to send those letters for approximately eight  
months was caused by its outsourcing of certain printing functions to a vendor called  
Duncan Printing Services. In that transition, PacifiCare failed to implement adequate  
monitoring and reconciliation controls that would have detected failures such as member

1 acknowledgment letters not being sent out for several months. In fact, a Duncan employee  
2 testified that had PacifiCare implemented certain monitoring and tracking tools that he  
3 repeatedly urged them to do, the company would have detected the issue with the member  
4 acknowledgment letters sooner.

5 Based on PacifiCare's representations during the MCE that the period that  
6 the acknowledgment-letter process was broken was from July 2006 until January 2007, and  
7 based on PacifiCare's admissions, CDI alleged 81,270 acts in violation. At the hearing  
8 PacifiCare produced additional data for claims paid during the MCE period, June 23,  
9 2006, to May 31, 2007. Among other things, these new data identified which claims were  
10 submitted by paper and which by EDI. Because PacifiCare has contended that claims  
11 submitted to it by EDI claims were electronically acknowledged, CDI used these new data  
12 to exclude EDI claims from its count of acknowledgment violations. CDI also excluded  
13 claims paid within 15 working days. Based on these new data, CDI is now alleging that  
14 PacifiCare failed to send provider acknowledgment letters for paper claims in at least  
15 55,475 instances, and failed to send member acknowledgment letters for paper claims in at  
16 least 988 instances. CDI also requested, but was denied, additional data sufficient to  
17 determine the number of paper claims for which PacifiCare failed to send acknowledgment  
18 letters from January 1, 2006, to June 22, 2006, and from June 1, 2007, through February  
19 29, 2008. Accordingly, there are an unknown number of additional acknowledgment  
20 violations during these periods that CDI has not alleged. In denying CDI's request for  
21 these data, however, the ALJ stated that PacifiCare's failures to send acknowledgment  
22 letters during these periods could be considered an aggravating factor that would  
23 potentially increase the per violation penalty amount for these violations.

24 PacifiCare previously acknowledged to CDI "it is required to send an  
25 acknowledgment letter for claims received, if the claim is not otherwise acknowledged by  
26 payment and/or issuance of an EOB within 15 calendar days," and admitted that it violated  
27 the law by not sending out acknowledgment letters. PacifiCare now has taken the position  
28 that the law doesn't require acknowledgment letters to be sent, but rather that an insurer

1 complies with the law by making acknowledgment information available for providers by  
2 website or telephone. PacifiCare argues that this interpretation is consistent with the  
3 DMHC's interpretation of its regulation regarding acknowledgment of claims, California  
4 Code of Regulations, title 28, section 1300.71, subdivision (c). PacifiCare also argues that  
5 the bill enacting the CDI acknowledgment statute, section 10133.66, subdivision (c), was  
6 intended to be modeled after the then-existing DMHC statutes and regulations.

7 PacifiCare contends that during the relevant period, it maintained a web  
8 portal and a telephone number that provided the necessary information. PacifiCare  
9 further claims that providers were notified in various ways that claim status information  
10 was available by website or by telephone. PacifiCare also asserted that their data showed  
11 that providers frequently use the telephone line to check status of claims. But the number  
12 PacifiCare cites for this proposition was for any calls having anything to do with claim  
13 status, not for calls specifically to verify the receipt of claims. In addition, PacifiCare  
14 witnesses admitted that its web portal was not available to non-contracted providers.  
15 PacifiCare witnesses also admitted that, even though it represented to the Department that  
16 its web portal made it compliant with the acknowledgment law, that portal did not provide  
17 information on the date that a claim was received, and it also failed to provide any claim  
18 information until the claim was fully adjudicated.

19 Contemporaneous PacifiCare documents adopt a different interpretation  
20 than the company's current interpretation of the acknowledgment law. At least as early as  
21 2004, PacifiCare intended, but failed, to send acknowledgment letters to providers. Indeed,  
22 it appears that PacifiCare interpreted the Fair Claims Settlement Practices Regulation,  
23 section 2695.5, subdivision (e), to require acknowledgment letters be sent to members and  
24 providers. Then, in 2005, when Senate Bill (SB) 634, which added section 10133.66,  
25 subdivision (c), to the Insurance Code, was enacted into law, PacifiCare generated  
26 documents called implementation logs and check-off lists that reflected the company's  
27 interpretation of that law and documented the actions that the company believed it was  
28 required to take under the law. Those internal PacifiCare documents showed that the

1 company interpreted SB 634 as requiring that claims be acknowledged in the same manner  
2 as they were received, and that acknowledgment letters be sent for paper claims. The  
3 legislative history of SB 634 similarly states that the law “[r]equires insurers to  
4 acknowledge receipt of a claim, in the same manner as the claim was received,” that is to  
5 say, paper claims must be acknowledged by paper letters.

6 Despite the fact that PacifiCare previously interpreted the acknowledgment  
7 statute as requiring acknowledgment letters for paper claims and conceded in 2007 the  
8 illegality of its failure to satisfy this requirement, it now also contends that it was not on  
9 notice of CDI’s interpretation of this statute. PacifiCare argues that it would be unfair to  
10 charge it with these violations because CDI never notified insurers that it interpreted the  
11 acknowledgment statute as requiring acknowledgment letters for paper claims.

12 PacifiCare has also offered testimony that providers are not harmed by not  
13 getting acknowledgment letters. Valerie Bigam, a medical billing administrator at a  
14 managed billing services organization, testified that she doesn’t want acknowledgment  
15 letters and that her company calls or uses insurer websites to check the status of claims.  
16 CDI witnesses have testified that the harm caused by not sending out an acknowledgment  
17 letter is, as a general matter, less severe as other violations such as incorrect claim  
18 payments. Ms. Wetzel testified that providers have told her that acknowledgment letters  
19 are useful to track when claims are received so they aren’t wasting time following up with  
20 insurers. She also testified that she trains physicians’ office staff to use the  
21 acknowledgment letters to avoid them from submitting duplicate, or “tracer,” claims.

22 Even though it now admits that it sent no provider acknowledgment letters  
23 during the MCE period, PacifiCare has asserted that even if acknowledgment letters are  
24 required, PacifiCare complied with the law 95% of the time. PacifiCare’s argument is that  
25 95% of all claims were processed before an acknowledgment letter was due or were claims  
26 submitted electronically that received an automatic acknowledgment.

27 PacifiCare further contends that it informed CDI about when member and  
28 provider acknowledgment letters were being sent out in a March 2008 meeting which

1 **PacifiCare has asserted was a confidential settlement meeting. PacifiCare witness, Nancy**  
2 **Monk, also testified that PacifiCare informed CDI at this meeting that the company's 800**  
3 **number constituted compliance with the acknowledgment requirement. On cross**  
4 **examination, Ms. Monk was questioned about the PowerPoint presentation that PacifiCare**  
5 **presented at that March 2008 meeting. That presentation fails to clearly disclose the dates**  
6 **that provider acknowledgment letters were not being sent. PacifiCare included in its**  
7 **presentation a chart that appeared to depict that provider acknowledgment letters were**  
8 **being sent at all times before June 1, 2006, which is false. This presentation also**  
9 **represented to CDI that PacifiCare's provider portal acknowledges the receipt of claims in**  
10 **compliance with the acknowledgment law. But as discussed above, PacifiCare's witnesses**  
11 **have since admitted that the portal did not provide information on the date that a claim**  
12 **was received, and failed to provide any claim information until the claim was fully**  
13 **adjudicated.**

14 **First, given this information, were these acts knowingly committed or**  
15 **performed with such frequency as to indicate a general business practice?**

16 A. Yes. PacifiCare is chargeable with knowledge of receipt of claims and the  
17 actions taken on them, constructive knowledge that makes the failure to send acknowledgments  
18 knowingly committed. Furthermore, the systems that were supposed to send out the  
19 acknowledgment letters are themselves business practices, which produce consistent non-  
20 compliant results under the circumstances presented here. The tens of thousands of claims that  
21 did not receive acknowledgment letters represent a frequency clearly indicating a general  
22 business practice.

23 **Q. Based on the information you have been given, was the issuance, amendment,**  
24 **or servicing of the policy or endorsement inadvertent, as that term is used in section**  
25 **790.035?**

26 A. No. PacifiCare's failure to send these letters does not constitute any sort of  
27 servicing of the policy, and it therefore cannot constitute the inadvertent servicing of the policy.

1 But even if the statute could be read to say that inadvertent *failure* to service the policy  
2 constitutes inadvertent servicing of the policy, that would not apply in this instance.

3 PacifiCare’s error in entering an “N” instead of a “Y” in RIMS may have been the result  
4 of a simple mistake back in 2004 when it was initially set up. But for years, PacifiCare failed to  
5 detect that it was not sending out provider acknowledgment letters. Indeed, there were multiple  
6 events over the course of this four-year period that should have caused PacifiCare to detect this  
7 failure, such as the enactment of SB 634 in 2005, which PacifiCare concluded required it to send  
8 acknowledgment letters to providers, and CDI’s referrals during the MCE that specifically  
9 requested information about PacifiCare compliance with the acknowledgment statute, section  
10 10133.66, subdivision (c). Yet PacifiCare failed to discover this deficiency, apparently until  
11 February 2008. PacifiCare’s failure to send required acknowledgment letters to providers for an  
12 approximately four-year period was the result of a reckless disregard for compliance with the  
13 law that cannot be called simple “inadvertence.”

14 Similarly, PacifiCare’s failure to send member acknowledgment letters for approximately  
15 eight months was not the result of an inadvertent servicing of the policy or an inadvertent failure  
16 to service the policy. It was the result of reckless decisions not to implement proper controls that  
17 would have detected such errors sooner.

18 **Q. Given this background information, do you classify these violations as willful**  
19 **or non-willful?**

20 A. It is clear that PacifiCare formed the intent to comply with the law, which leads  
21 me to conclude that its failure to do so was not willful. It is true that PacifiCare should have  
22 known that acknowledgment letters were not being sent out long before it discovered this failure.  
23 In particular, in response to CDI’s referrals in October 2007, inquiring about the company’s  
24 compliance measures for section 10133.66, subdivision (c), and specifically requesting copies of  
25 sample provider acknowledgment letters, PacifiCare should have discovered that it was not  
26 sending out these letters at that time, in October 2007. Nevertheless, for present purposes, I will  
27 consider these to be non-willful acts in violation of the law.  
28

1           **Q.     Now, in light of the facts you have been asked to assume and the factors**  
2 **enumerated in section 2695.12, what penalty would you propose for this category of alleged**  
3 **violations?**

4           A.     First, I have seen no evidence of the existence of extraordinary circumstances  
5 (Reg. § 2695.12, subd. (a)(1)), as that term is defined in the Regulations (Reg. § 2695.2,  
6 subd. (e)).

7                     I also did not see evidence that acknowledging these claims would have been  
8 complex, or that the claims that didn't receive proper acknowledgment were themselves  
9 complex. (Reg. § 2695.12, subd. (a)(3).)

10                    The relative number of claims where the noncomplying acts were found to exist is  
11 an aggravating factor. (Reg. § 2695.12, subd. (a)(7).) During the MCE period, PacifiCare failed  
12 to send any provider acknowledgment letters for paper claims, reflecting a 100% noncompliance  
13 rate. PacifiCare failed to send any member acknowledgment letters for approximately 8 of the  
14 11 months reviewed during the MCE, indicating a high noncompliance rate. PacifiCare's  
15 assertion that it had a 95% compliance rate for provider acknowledgment letters is misleading  
16 and does not reflect the insurer's performance with respect to this requirement, given that  
17 PacifiCare admits that no provider acknowledgment letters were being sent during the MCE  
18 period (and for significant periods before and after).

19                    PacifiCare did ultimately undertake remedial actions to send out member  
20 acknowledgment letters in March 2007 and provider acknowledgment letters in March 2008.  
21 (Reg. § 2695.12, subd. (a)(8).) With respect to the provider acknowledgment letters, that  
22 remedial action was only taken after CDI raised this issue with the company. I further  
23 considered PacifiCare's apparent failure to determine why it failed to discover for months and  
24 years that acknowledgment letters were not being sent. Because for purposes of this factor, I am  
25 only considering the mere fact that remedial actions were taken, not the delay in taking them, I  
26 find this to be a slightly mitigating factor.

27                    For the reasons previously discussed, the existence or nonexistence of previous  
28 violations factor is inapplicable in this case. (Reg. § 2695.12, subd. (a)(9).)

1 As discussed above, the harm from failing to send acknowledgment letters is  
2 generally the additional administrative burden imposed on claimants. (Reg. § 2695.12, subd.  
3 (a)(10).) The testimony offered in this hearing confirms this. That PacifiCare presented one  
4 witness to testify that her company doesn't want or use acknowledgment letters does not mean  
5 that that is the view of all providers. The fact that the Legislature saw fit to impose this  
6 requirement, and the fact that it did so in part at the behest of representatives of providers,  
7 precludes the Department from treating it as if disobedience is harmless. I have seen no  
8 evidence that indicates the degree of harm occasioned by these violations was any greater or any  
9 less than in the ordinary case.

10 Under the totality of circumstances, I do not believe PacifiCare exhibited a good  
11 faith attempt to comply with these Regulations; in fact, I believe the company acted in bad faith  
12 in this regard. (Reg. § 2695.12, subd. (a)(12).) Based on the assumptions I have been given, I  
13 have seen multiple misrepresentations to CDI regarding these violations that not only show bad  
14 faith by the licensee but also represent violations of Regulation section 2695.5, subdivision (a).  
15 Several of these misrepresentations appear to have been intended to conceal the full extent of  
16 PacifiCare's noncompliance. Such lack of candor is a very serious concern to the Department  
17 and represents a significant harm to the process, for effective regulation depends in large part on  
18 the honesty and forthrightness of licensees.

19 I considered PacifiCare's contention that its telephone number and portal  
20 constituted compliance with the acknowledgment statute. That does not constitute a good faith  
21 attempt to comply by PacifiCare. The Legislature (as reflected in the legislative history) and the  
22 Department do not interpret the law in this manner, and apparently neither did PacifiCare before  
23 it was charged with these acknowledgment violations. In fact, PacifiCare's assertions to CDI  
24 that the company complied with the acknowledgment statute by having a portal was another  
25 misrepresentation. Section 10133.66, subdivision (c), requires that the insurer provide the date  
26 that the claim was received, which according to PacifiCare witness, Nancy Monk, the company's  
27 portal fails to do. This is a significantly aggravating factor.

1 Failing to send member acknowledgment letters for eight months and provider  
2 acknowledgment letters for over two years reflects a high frequency. (Reg. § 2695.12, subd.  
3 (a)(12).) However, I did not see evidence that the detriment to the public was particularly  
4 severe.

5 I believe that PacifiCare management should have been aware of the failures to  
6 send these acknowledgment letters years before the company remediated these issues. (Reg. §  
7 2695.12, subd. (a)(13).) PacifiCare intended to send provider and member acknowledgment  
8 letters sometime in 2004, but for some reason letters to providers were not sent out at that time.  
9 That failure continued from 2004 through 2005, when in response to the passage of SB 634,  
10 PacifiCare re-examined its policies and procedures with respect to provider acknowledgment  
11 letters. At that time, PacifiCare should have detected, but apparently didn't detect, that it was  
12 failing to send these letters. Then, for almost two years, it failed to detect that provider  
13 acknowledgment letters were not being sent out. During the 2007 MCE, in response to CDI's  
14 data request for dates that claims were acknowledged during the review period, PacifiCare again  
15 should have discovered that it was not sending provider acknowledgment letters at that time.  
16 PacifiCare should have yet again discovered this failure in responding to CDI's two October  
17 2007 referrals regarding PacifiCare's acknowledgment procedures, one of which specifically  
18 asked PacifiCare to produce sample acknowledgment letters. Similarly, PacifiCare failed to send  
19 member acknowledgment letters for approximately eight months without detection. That  
20 PacifiCare had so many opportunities to discover and then remediate these problems, yet failed  
21 to do so, makes this a significantly aggravating factor.

22 On balance, I find that these factors represent a set of circumstances that are  
23 significantly aggravating, as compared to the generic acknowledgment violation. In particular,  
24 based on PacifiCare's repeated misrepresentations to and lack of candor with the Department;  
25 based on the length of time that these violations persisted without PacifiCare detecting and  
26 remediating them; and because there are likely a significant, but unknown, number of unalleged  
27 violations, I think it appropriate to increase the per violation penalty by at least 50%, from  
28 \$1,000 to \$1,500 per act in violation.

1           **Q.     So that results in 56,463 acts in violation of the law at \$1,500 per act. Are**  
2 **there any other adjustments you think are appropriate?**

3           A.     Yes. For the reasons previously discussed, I think it appropriate to reduce the per  
4 violation penalty by 50% after the first 50,000 violations. Therefore, my recommended  
5 aggregate penalty for these violations is  $50,000 \times \$1,500 + 6,463 \times \$750$ , or \$79,847,250, for the  
6 56,463 violations.

7           **L.     PacifiCare’s Failure to Timely Respond to Provider Disputes**

8           **Q.     Are you aware of the allegations that PacifiCare failed to issue written**  
9 **determinations in response to provider disputes within 45 working days, in violation of the**  
10 **law?**

11          A.     Yes.

12          **Q.     Do failures to issue written determinations of provider disputes within 45**  
13 **working days violate the Insurance Code or the Fair Claims Settlement Practices**  
14 **Regulations?**

15          A.     Yes. Insurance Code section 10123.137, subdivision (a), requires providers to  
16 implement a “fast, fair, and cost-effective dispute resolution mechanism.” Subdivision (c) of the  
17 same section requires the insurer to resolve each provider dispute and issue a written  
18 determination within 45 working days. Failure to resolve provider disputes within the statutory  
19 period also violates Insurance Code section 790.03, subdivision (h)(2), because the insurer is not  
20 acting reasonably promptly upon communications with respect to claims. Such denials also  
21 violate section 790.03, subdivision (h)(3), because they reflect failures to adopt and implement  
22 reasonable standards for prompt investigation and processing of claims arising under insurance  
23 policies.

24          **Q.     In general, how would you rate the severity of the failure to respond to**  
25 **provider disputes within 45 working days?**

26          A.     It is a moderately serious violation. Although not as serious as a violation that,  
27 by its nature, would cause a patient to be denied medical care or presents a serious risk of bodily  
28 injury, it is a significant concern.

1 The prompt and accurate payment of claims is, of course, critical to the provider, the  
2 patient, the insurer, and the healthcare system. The requirement that insurers timely adjudicate  
3 provider disputes is a central feature of the system established by the Legislature to guarantee  
4 appropriate and timely claim processing. In my experience, the inability to obtain redress from  
5 the insurer typically leads providers either to abandon efforts to get their claims paid properly, or  
6 to turn to the Department for assistance. The former reaction means that providers may not be  
7 getting reimbursed appropriately, and the latter can mean that the Department is deluged with  
8 provider complaints.

9 **Q. Where do you place this type of violation on the section 790.035 spectrum**  
10 **from zero to either \$5,000 or \$10,000 per act in violation?**

11 A. I would set it at 40% of the penalty range, or \$2,000 for a non-willful act in  
12 violation and \$4,000 for a willful act in violation.

13 **Q. Now, let me describe for you the background on these particular violations.**  
14 **Please assume the following facts:**

15 **As you know, effective January 1, 2006, Insurance Code section 10123.137**  
16 **required insurers to establish a dispute resolution procedure available to both contracted**  
17 **and non-contracted providers, to inform providers how to submit a dispute, and to resolve**  
18 **all disputes and communicate their determinations to the providers in writing within 45**  
19 **working days of receipt. PacifiCare was aware of this requirement at the time of**  
20 **enactment.**

21 **PacifiCare received no provider disputes in June 2006 and five in July 2006.**  
22 **In August, shortly after implementation of EPDE and the transition of mail processing to**  
23 **Lason, provider disputes rose to 226, and were over 1,000 per month by October 2006.**  
24 **Beginning in November 2006, CDI noted a spike in complaints from providers angry about**  
25 **underpayments, improper denials, and the “frustration of trying to work with PLHIC and**  
26 **their provider dispute program and not being able to get a resolution.” Contributing to**  
27 **provider frustration was the fact that customer service representatives did not have ready**  
28

1 access to the provider dispute tracking tool and could not transfer providers to the  
2 appropriate staff, so phone calls to inquire about the status of a dispute were ineffective.

3 In March 2007, the CMA filed a complaint with the Department addressing,  
4 among other problems, PacifiCare's failure to respond to provider complaints. CMA  
5 provided documentation to CDI about breakdowns at PacifiCare in responding to provider  
6 inquiries and complaints. One doctor, for instance, made at least 35 calls to PacifiCare in  
7 an effort to resolve a contract loading problem that was causing him to be paid incorrectly,  
8 many of which went unreturned and all of which were ineffective in resolving the issue.  
9 When Mr. Wichmann reviewed the documentation on that doctor, he acknowledged that if  
10 the account was accurate, it would be unacceptable to him.

11 CDI asked PacifiCare for a copy of its formal provider dispute resolution  
12 ("PDR") procedures, which PacifiCare provided three months later. CDI included  
13 provider disputes among the issues it investigated in the market conduct exam. CDI  
14 examiners reviewed 96 provider dispute files and identified 14 instances in which no  
15 written determination was provided within the statutory period. PacifiCare reported that  
16 it had received 16,653 provider disputes during the MCE review period, of which 15,052  
17 were timely responded to and 1,510 were not. PacifiCare disclosed that problems with  
18 DocDNA that delayed the transmission of correspondence from Lason to the rework team  
19 were primary reason for its failure to timely process provider disputes. As Ms. Berkel  
20 stated in an internal memo: "We are failing California law and it is late routing."

21 In early September 2007, Dirk McMahon, UnitedHealthcare's Chief  
22 Operating Officer, diagnosed PDR as an "orphaned process" and "clearly one of our  
23 biggest challenges." In addition to the need to improve DocDNA routing, Mr. McMahon  
24 identified the need to increase the number of staff assigned to processing provider disputes  
25 and to "harden" REVA, the application on which the disputes were processed, by adding  
26 additional servers and obtaining appropriate IT support.

27 PacifiCare undertook some corrective actions with respect to handling of  
28 provider disputes in late 2007 and early 2008, enhancing REVA's routing capability,

1 auditing PDR quality, and forming a corrective action team dedicated to improving the  
2 PDR process. Five months after Mr. McMahon's email, however, no servers had been  
3 added and REVA's existing servers were "at or near maximum" capacity. PacifiCare  
4 discussed bringing some of the PDR review functions that had been outsourced to Lason  
5 back in-house due to the "highly complex" and "strictly regulated" nature of provider  
6 disputes, but decided to give Lason additional training and "see if quality can improve."  
7 PacifiCare did not revamp its correspondence routing process until May 2008.

8 **First, given this information, were these acts knowingly committed or**  
9 **performed with such frequency as to indicate a general business practice?**

10 A. Yes. PacifiCare is charged with knowledge of when it receives provider disputes  
11 and when and how it responds to those disputes. Absent evidence that the company had a  
12 reasonable basis to be unaware of these facts, PacifiCare's failure to timely respond to provider  
13 disputes was knowingly committed.

14 Further, PacifiCare was fully aware of the steps it was taking when it altered the  
15 flow of PDR documents and was chargeable with the knowledge that carelessness and haste  
16 would likely result in misrouting and mishandling of provider disputes. As the evidence quickly  
17 mounted in mid-2006 of problems with the handling of claims, the increase in provider disputes  
18 was entirely foreseeable and the failure to tool up to handle them was knowing. Furthermore,  
19 the number of mishandled disputes, over 1,500 by PacifiCare's count, is sufficient to indicate a  
20 general business practice.

21 **Q. Based on the information you have been given, was the issuance, amendment,**  
22 **or servicing of the policy or endorsement inadvertent, as that term is used in section**  
23 **790.035?**

24 A. No. I have been given no reason to conclude that PacifiCare was inadvertently  
25 servicing the policies when it responded to the provider disputes at issue here.

1           **Q.     Given this information, do you classify these violations as willful or non-**  
2 **willful?**

3           A.     These are willful violations. PacifiCare has acknowledged that the failure to  
4 timely respond to provider disputes was caused by its fundamentally flawed document routing  
5 process. PacifiCare knew that provider disputes were among the correspondence items being  
6 misrouted by Lason or sitting in DocDNA queues for weeks. As discussed above, the design  
7 and implementation of the document-routing system, lack of oversight from PacifiCare  
8 management, and serious delay in establishing quality control mechanisms and redesigning the  
9 document routing procedures reflect a willful failure to adopt reasonable standards related to  
10 claims and a willingness to not promptly respond to communications from providers.

11           **Q.     So your baseline penalty per act in violation of this provision is 40% of**  
12 **\$10,000, or \$4,000?**

13           A.     Yes.

14           **Q.     Now, in light of the facts you have been asked to assume and the factors**  
15 **enumerated in section 2695.12, what penalty would you propose for this category of alleged**  
16 **violations?**

17                     First, I have seen no evidence of the existence of extraordinary circumstances  
18 (Reg. § 2695.12, subd. (a)(1).)

19                     Provider disputes tend to be relatively complicated to adjudicate, which is a  
20 slightly mitigating factor. (Reg. § 2695.12, sub. (a)(3).) However, the law accounts for this  
21 increased complexity by allowing insurers 45 working days, more time than the standard 30  
22 working days to process a claim.

23                     During the MCE, CDI examiners found 14 violations in a review of 96 provider  
24 dispute files. That is a high relative number of noncomplying acts, and an aggravating factor.  
25 (Reg. § 2695.12, subd. (a)(7).)

26                     PacifiCare undertook remedial measures to improve its adjudication of provider  
27 disputes. (Reg. § 2695.12, subdivision (a)(8).) However, I saw no evidence that some important  
28 measures that were identified by the company, such as adding server space and bringing the

1 processing of provider disputes back in-house, were implemented. I also note that the root cause  
2 of provider dispute violations was the DocDNA routing process, which, as discussed above, was  
3 remediated only belatedly.

4 The factor considering whether PLHIC had committed previous violations of this  
5 kind is not relevant here. (Reg. § 2695.12, subd. (a)(9).)

6 As previously discussed, the general harm from this type of violation includes the  
7 time spent by providers pursuing review of wrongly denied or improperly adjudicated claims,  
8 and the frustration from not receiving a timely response. (Reg. § 2695.12, subdivision (a)(10).)  
9 The harm here was exacerbated by PacifiCare's inadequate customer service, which did not  
10 permit providers to resolve complaints informally or to ascertain whether their written disputes  
11 were being processed. There is also the underlying harm of claims violations that could have  
12 been remedied, or remedied more quickly, if PacifiCare had timely responded to the dispute,  
13 which the documentation from the CMA confirms occurred here. Finally, there is the increased  
14 burden on the Department. The Department devoted significant resources to investigating  
15 complaints from providers who were unable to obtain redress from PacifiCare. While some of  
16 these may have been cases where PacifiCare upheld its original determination, thereby  
17 complying with the statute, and the provider sought further review, in many instances the  
18 provider simply did not receive a response.

19 Under the totality of circumstances, I do not believe PacifiCare exhibited a good  
20 faith attempt to comply with these Regulations. (Reg. § 2695.12, subd. (a)(12).) I took into  
21 consideration PacifiCare's voluntary disclosure to CDI of the number of provider disputes  
22 received during the market conduct period and how many were timely adjudicated. I also note,  
23 however, that it took PacifiCare three months to give the Department a copy of its provider  
24 dispute resolution procedure. More importantly, the root cause of these violations is PacifiCare's  
25 refusal to invest in appropriate testing and quality control measures for handling documents, such  
26 as provider disputes, received through the mail. By the company's own account, it "orphaned" a  
27 process that was essential to both compliance with the law and fair treatment of providers.

1           The frequency of the violations, 1,510 over an eleven-month period, is fairly high  
2 for this type of violation. (Reg. § 2695.12, subd. (a)(12).) This number reflects PacifiCare's  
3 mishandling of provider claims and the inability to resolve issues over the phone. The severity  
4 of detriment to the public as a whole is difficult to calculate, but I will conservatively assume  
5 that the detriment to the public was not severe.

6           PacifiCare was well aware of the statutory requirement to respond promptly to  
7 provider disputes, and was aware that its existing PDR processes were insufficient to allow it to  
8 meet its obligations. (Reg. § 2695.12, subd. (a)(13).) The company addressed those problems  
9 slowly and in a piecemeal fashion. For example, the fact that PacifiCare reorganized its  
10 document routing process in May 2008, almost two years after the mail routing problems began  
11 and six months after Mr. McMahon pointed out the need to improve DocDNA routing, shows an  
12 inattention and lack of urgency about addressing problems that it knew to be causing violations  
13 of law.

14           On balance, I believe these factors represent a set of circumstances that are  
15 slightly aggravating, as compared to the generic violation of requirement to timely process  
16 provider disputes. I therefore think it appropriate to increase the penalty by 10%, from \$4,000 to  
17 \$4,400 per act in violation. My recommended penalty for this group of violations is therefore  
18 \$6,644,000, for these 1,510 violations.

19           **M. PacifiCare's Illegal Practice of Closing or Denying Claims When**  
20           **Requesting Additional Information**

21           **Q. Are you aware of the allegations that PacifiCare closed or denied claims**  
22           **when requesting additional information in violation of law?**

23           A. Yes.

24           **Q. Does closing or denying claims when an insurer needs additional information**  
25           **constitute a violation of the Insurance Code or the Fair Claims Settlement Practices**  
26           **Regulations?**

27           A. Yes. The closing or denying of claims when requesting additional information, if  
28 committed knowingly or performed with such a frequency as to indicate a general business

1 practice, constitutes a violation of Insurance Code section 790.03, subdivision (h)(1), because it  
2 represents a misrepresentation of a pertinent fact relating to coverages. It also violates section  
3 790.03, subdivision (h)(3), because it reflects a failure to adopt and implement reasonable  
4 standards for the prompt investigation and processing of claims. It further violates sections  
5 10123.13, subdivision (a), and 10123.147, subdivision (a), which require that claimants be  
6 notified if a claim is being contested. Though PacifiCare was contesting these claims, it  
7 wrongly notified claimants that the claims were being closed or denied. PacifiCare's practice  
8 also violates Regulation section 2695.7, subdivision (d), because the company failed to "conduct  
9 and diligently pursue a thorough, fair and objective investigation" by closing or denying claims  
10 for which it needed additional information to process.

11 **Q. As a general proposition, how serious an act in violation of the law do you**  
12 **view it to be when a company closes or denies claims when it needs additional information?**

13 A. In comparison to the range of violations to which section 790.035 applies, I view  
14 this as being of average seriousness. Closing or denying a claim because the insurer claims to  
15 need additional information is a wrongful claim denial. In fact, a claimant receiving notification  
16 that a claim is being closed or denied because the insurer needs information may be confused  
17 about the status of that claim. The claimant may reasonably believe that the insurer's closure or  
18 denial of the claim is the final determination on that claim.

19 **Q. As a general proposition, where do you place this type of violation on the**  
20 **section 790.035 spectrum from zero to either \$5,000 or \$10,000 per act in violation?**

21 A. Consistent with my description of this type of violation as being of average  
22 seriousness, I would put it at 50% of the way from zero to the maximum, or \$2,500 per act for  
23 non-willful acts and \$5,000 per act for willful acts.

24 **Q. Let me describe for you the background of these violations. Please assume**  
25 **the following facts:**

26 **From at least December 2005 to sometime in 2007, PacifiCare's practice**  
27 **when it was contesting a claim because it purportedly needed additional information was to**  
28 **close or deny that claim. PacifiCare would inform members and providers on EOBs that**

1 **their claim was being closed or denied due to lack of required information. Specifically,**  
2 **several EOBs dated in 2006 contained a remark code “px” that stated:**

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

8 **Several EOBs dated in 2005 to 2007 contained a remark code “iq” that stated:**

9 **“Claim was closed due to lack of response to a prior request for**  
10 **other insurance information. Services will be reconsidered and patient**  
11 **responsibility will be calculated upon receipt. Please refer to your**  
12 **Certificate, ‘Payment Responsibility, Right to Receive and Release**  
13 **Information.’”**

14 **Each of these EOBs that contained this notice was for a claim that had not previously been**  
15 **processed, and therefore no prior request for other insurance information had ever been**  
16 **made.**

17 **In addition, based on complaints against PacifiCare filed with CDI, the**  
18 **Department cited PacifiCare for 2 violations based on the company’s denial of claims using**  
19 **the “px” remark code when the additional information was being requested. In those**  
20 **violation letters, CDI explained: “The claim was denied and closed rather than contested or**  
21 **delayed to request additional information such as, a copy of the Certificate of Creditable**  
22 **Coverage or prior Medical Records to properly determine if the claim was for an actual**  
23 **pre-existing condition and not just a potential pre-existing condition. This places an undue**  
24 **burden upon the provider/claimant and the insured to appeal and overcome a denial rather**  
25 **than to provide reasonably necessary information, requested by the insurer to make an**  
26 **informed determination to accept or deny the claim.”**

27 **CDI does not have data on the total number of PacifiCare EOBs that closed**  
28 **or denied claims on these bases. Therefore, CDI is alleging 52 acts in violation based on the**  
29 **violation letters, EOBs that are in evidence, and claim spreadsheets indicating “iq” or “px”**  
30 **remark codes.**

1                   **First, given this information, were these acts knowingly committed or**  
2 **performed with such frequency as to indicate a general business practice?**

3           A.     Yes. PacifiCare knew, or should have known, of its practice of sending out EOBs  
4 containing this language that denied or closed claims when the insurer was requesting additional  
5 information. All insurers are, of course, chargeable with knowledge that the law requires it to  
6 contest, not to deny, a claim in which it is requesting additional information; the affirmative act  
7 of requesting additional information amounts to an admission that it lacked the information to  
8 deny the claim. Furthermore, PacifiCare knew, or should have known, that denial of a claim is  
9 likely to be understood by some claimants as final and to discourage them from further efforts to  
10 obtain payment. And while the Department observed only 52 instances of such denials, this  
11 appears to have been PacifiCare's company practice uniformly applied to every instance in which  
12 the company was requesting additional information, an obvious general business practice.

13           **Q.     Based on the information you have been given, was the issuance, amendment,**  
14 **or servicing of the policy or endorsement inadvertent, as that term is used in section**  
15 **790.035?**

16           A.     No. I have been given no information suggesting that PacifiCare was  
17 inadvertently servicing these policies when it sent out these EOBs.

18           **Q.     Given this background information, do you classify these violations as willful**  
19 **or non-willful?**

20           A.     I will consider these to be non-willful violations. While it is clear that PacifiCare  
21 knew or should have known that by denying and closing these claims, it was misrepresenting  
22 pertinent facts and was failing to adopt and implement reasonable standards for the prompt  
23 investigation and processing of claims, I have not seen sufficient evidence that it did so  
24 willfully.

25           **Q.     Now, in light of the facts you have been asked to assume and the factors**  
26 **enumerated in section 2695.12, what penalty would you propose for this category of alleged**  
27 **violations?**

28

1           A.       First, I have seen no evidence of the existence of extraordinary circumstances  
2 (Reg. § 2695.12, subd. (a)(1)), as that term is defined in the Regulations (Reg. § 2695.2, subd.  
3 (e)).

4                       While questions of prior coverage and exclusion period are more complex than  
5 the issues encountered in the typical claim, wrongfully denying the claims does not appear to  
6 have been attributable to that complexity. (Reg. § 2695.12, subd. (a)(3).)

7                       I have not seen sufficient evidence to assess the relative number of claims where  
8 the noncomplying acts were found to exist. (Reg. § 2695.12, subd. (a)(7).) It appears that from  
9 December 2005 to sometime in 2007, PacifiCare would close or deny claims in every instance in  
10 which it was requesting additional information, but I have been given no information on the total  
11 number of claims that the Department reviewed during that period.

12                      I also have seen no evidence of whether PacifiCare has taken remedial measures  
13 with respect to these violations. (Reg. § 2695.12, subd. (a)(8).)

14                      For the reasons previously discussed, the existence or nonexistence of previous  
15 violations factor is inapplicable in this case. (Reg. § 2695.12, subd. (a)(9).)

16                      As discussed above, the harm from these types of violations is that claims are  
17 being incorrectly denied, which may cause claimants to be confused and result in them not  
18 submitting the requested information. The language PacifiCare provided on its EOBs confirms  
19 this concern. The “px” remark code language on the 2006 EOBs does instruct the claimant to  
20 send in a COCC or the names and addresses of prior doctors and to refer to the Certificate, but it  
21 does not explain that PacifiCare’s denial of the claim will be reconsidered upon receipt of that  
22 information. This will likely create confusion and may result in claimants not submitting the  
23 requested information because they believe that their claim has been denied. In that instance, the  
24 incorrect denial would never be remediated, which I consider to be significant harm. The  
25 language for the “iq” remark code on the 2005-2007 EOBs does state that services will be  
26 reconsidered and patient responsibility will be calculated upon receipt of the requested  
27 information, but it does not explain what requested information the claimant is being asked to  
28 submit. Rather, this language informs the claimant that the claim is being closed due to lack of

1 response to a prior request for other insurance information when there has been no prior request  
2 for other insurance information. This is very confusing, and similarly may result in the claimant  
3 never sending in the requested information. Nevertheless, I believe that these specific violations  
4 are no more or less harmful than such violations would be in general, and find this to be neither  
5 an aggravating or mitigating factor.

6 I saw no evidence either way regarding PacifiCare's good faith attempt to comply. (Reg.  
7 § 2695.12, subd. (a)(12).)

8 I also did not see sufficient evidence to consider the frequency of these violations, and I  
9 believe the detriment to the public was no more or less than in the ordinary case. (Reg. §  
10 2695.12, subd. (a)(12).) This factor is neither aggravating nor mitigating.

11 I believe that PacifiCare management should have been aware of this practice of illegally  
12 closing or denying claims when requesting additional information, but I am unaware of whether  
13 or when PacifiCare took remedial measures. (Reg. § 2695.12, subd. (a)(13).) At a minimum this  
14 practice continued from at least December 2005 to sometime in 2007, however. This is a  
15 slightly aggravating factor.

16 On balance, I find that these factors represent a set of circumstances that are aggravating,  
17 as compared to the generic violation. I think it appropriate to increase the per violation penalty  
18 by at least 5 percent, from \$2,500 to \$2,625 per act in violation. Therefore, my recommended  
19 aggregate penalty for this category is \$136,500, for the 52 violations.

20 **N. PacifiCare's Sending of Untimely Collection Notices on Overpaid**  
21 **Claims**

22 **Q. Are you aware of the allegations that PacifiCare issued untimely demands for**  
23 **reimbursement of purported overpayments to providers in violation of law?**

24 A. Yes.

25 **Q. Do untimely reimbursement demands sent more than 365 days after the date**  
26 **the claim was initially paid violate the Insurance Code or the Fair Claims Settlement**  
27 **Practices Regulations?**

1           A.     Yes. Sending untimely demands for reimbursement, if committed knowingly or  
2 performed with such a frequency as to indicate a general business practice, constitute violations  
3 of Insurance Code section 790.03, subdivision (h)(1), because they reflect misrepresentations to  
4 claimants of pertinent facts relating to coverage at issue. They are also violations of section  
5 790.03, subdivision (h)(3), because sending such untimely demand letters reflects a failure to  
6 adopt and implement reasonable standards for prompt investigation and processing of claims  
7 arising under insurance policies. They also violate section 10133.66, subdivision (b), which  
8 requires that reimbursement requests be sent in writing within 365 days of the date of payment  
9 on the overpaid claim.

10           **Q.     As a general proposition, how serious an act in violation of the law do you**  
11 **view it to be when a company sends untimely reimbursement demands to providers?**

12           A.     In comparison to the range of violations to which section 790.035 applies, I view  
13 sending untimely reimbursement demands as moderately serious. As a general matter, such  
14 violations will not result in severe harm such as a patient being denied medical care, but it is still  
15 a cause for concern.

16           Sending untimely reimbursement requests can create significant administrative burdens  
17 on providers who must track down and review old claims to verify that they were overpaid. In  
18 addition, providers may be forced to collect additional sums from patients, which can harm  
19 members and adversely affect the doctor-patient relationship. Untimely reimbursement requests  
20 also may have a negative financial impact on providers because they are being asked to repay  
21 money that they may have already accounted for as revenue. And if the insurer waits more than  
22 a year to demand repayment, then obtains repayment, and then is required to refund the  
23 repayment, the cost, inconvenience, and confusion to provider and consumer can be significant.

24           **Q.     As a general proposition, where do you place this type of violation on the**  
25 **section 790.035 spectrum from zero to either \$5,000 or \$10,000 per act in violation?**

26           Consistent with my description of this type of violation as moderately serious, I  
27 would put it at 30% of the way from zero to the maximum, or \$1,500 per act for non-willful acts  
28 and \$3,000 per act for willful acts.

1           **Q. Let me describe for you the background of these violations. Please assume**  
2 **the following facts:**

3           **In May 2007, United began integrating PacifiCare’s overpayment collection**  
4 **functions into United’s Audit Recovery Operations (ARO) department. In January 2008,**  
5 **United assigned several thousand PacifiCare PPO claims to one of United’s debt recovery**  
6 **vendors, Johnson & Rountree Premium (J&R), to collect alleged overpaid amounts. These**  
7 **claims, known as the PLHIC Historical Claims, were paid years before, dating back as far**  
8 **as January 2004, but United believed that PacifiCare had previously sent initial letters**  
9 **demanding repayment. Almost immediately, as early as January 4, 2008, J&R began**  
10 **sending letters to providers demanding repayment of allegedly overpaid claims. These**  
11 **letters were designated as “Second Request” letters and asserted that the company had**  
12 **previously requested reimbursement from the provider but had not received the refund.**  
13 **The letters further told providers: “If a response is not received, PacifiCare may offset**  
14 **future payments by the refund amount requested.”**

15           **In early to mid-2008, the CMA forwarded to PacifiCare complaints from two**  
16 **providers regarding these demands for repayment. One of the physicians, Dr. Theodore**  
17 **Mazer, received a letter on April 8, 2008, requesting repayment of \$49.13 on a claim that**  
18 **was initially paid on October 18, 2005; the letter identified this claim as a Secure Horizons**  
19 **claim. The letter also indicated that this was a second request for repayment, but Dr.**  
20 **Mazer testified that he never received a first request. Dr. Mazer’s records indicated that**  
21 **someone from his office contacted PacifiCare in October 2005 to inform it of the**  
22 **overpayment and was told that PacifiCare would reprocess the claim. But Dr. Mazer never**  
23 **received anything from PacifiCare on this claim until two-and-a-half years later when he**  
24 **received the J&R overpayment demand letter. PacifiCare contends that its records reflect**  
25 **that a first request for repayment was sent to Dr. Mazer on November 16, 2005, but the**  
26 **company was unable to locate a copy of that first request letter. PacifiCare further**  
27 **admitted that the claim at issue was not for a Secure Horizons member, as the letter**  
28 **incorrectly indicated. PacifiCare withdrew its request for repayment on this claim on**

1 April 22, 2008. The other provider complaint came from Dr. Noelle Chiu who received a  
2 request for repayment on a claim paid on January 22, 2007, that the provider contended he  
3 already reimbursed. PacifiCare investigated this complaint and determined that the  
4 provider was correct that he had already reimbursed PacifiCare and the check was cashed  
5 on April 17, 2007. PacifiCare determined that although PacifiCare had received the  
6 paperwork, the appeals processor had failed to record that the matter should be closed.  
7 Therefore, J&R continued to send letters on this matter. PacifiCare investigated another  
8 provider complaint from Dr. Myron Bloom, which was forwarded to PacifiCare by CDI,  
9 and determined that it could not locate the first request letter, though it claimed that its  
10 records indicated that it was timely sent in 2005.

11 On May 22, 2008, PacifiCare instructed J&R to cease all open overpayment  
12 recoveries on the PLHIC Historical Claims. PacifiCare also began auditing each of these  
13 claims to determine whether a first request letter had previously been timely sent within  
14 365 days of payment. By the end of June 2008, PacifiCare had determined that of the 5,224  
15 reimbursement requests sent to providers, 2,912 were invalid and needed to be canceled.  
16 At that time, PacifiCare had located only several hundred first request letters.

17 J&R employee Jacob Cassady testified that J&R was told that PacifiCare  
18 had sent first request letters on these claims and that J&R was following its instructions  
19 from PacifiCare in sending out these second request letters. At the hearing, Ms. Berkel  
20 admitted that the company “did not appropriately look for the initial claim overpayment  
21 recovery letter before we instructed our vendor, Johnson & Rountree, to initiate a second  
22 recovery letter on certain items, on some PLHIC overpayment claim recoveries.” No one  
23 at United was assigned responsibility for verifying the existence of these first request letters  
24 before instructing J&R to send the second request letters.

25 In advance of the May 13, 2010, testimony of Brian Bugiel, who was  
26 designated as the person most knowledgeable from United about the J&R overpayment  
27 issues, PacifiCare again attempted to search for additional first request letters. In this  
28 search, PacifiCare claims to have found hundreds of additional first request letters.

1 **PacifiCare also produced to CDI data that reflected that there were 4,831 PacifiCare PPO**  
2 **claims for which J&R sent untimely overpayment demand letters, each of which the**  
3 **Department alleged as a violation of law.**

4 **After his testimony in May, Mr. Bugiel again went back to his office to look**  
5 **for more first request letters on these claims. In this mid-2010 search, PacifiCare claims to**  
6 **have located over 2,000 such letters. Based on this additional search, PacifiCare admitted**  
7 **that there were 1,934 claims for which PacifiCare either was unable to find a first request**  
8 **letter or had sent an untimely first request letter, though it asserts that there were 560**  
9 **claims that were initially paid before January 1, 2006, when section 10133.66, subdivision**  
10 **(b), became effective. PacifiCare's request for repayment on each of those 560 claims,**  
11 **however, was made in 2008, after that statute became effective.**

12 **PacifiCare also now contended the data previously produced to CDI**  
13 **mistakenly included non-California claims; of the 4,831 alleged violations, PacifiCare**  
14 **asserted that 204 related to non-California claims. PacifiCare further contended that there**  
15 **were 88 claims in those data that were never pursued for overpayment recovery. In**  
16 **addition, according to PacifiCare, there were 596 claims that were not pursued for**  
17 **secondary recovery, though PacifiCare did not know whether a first request for recovery**  
18 **had been sent. PacifiCare also asserted that 163 of the alleged violations related to claims**  
19 **that providers voluntarily repaid. However, PacifiCare's data were inconsistent with this**  
20 **assertion. For a significant majority of those claims that PacifiCare contended the**  
21 **provider voluntarily repaid, the data showed that the company recovered no money from**  
22 **the provider and closed the claim in the full amount of the recovery request. Mr. Bugiel's**  
23 **only explanation for this discrepancy was that the data may be wrong. There was also a**  
24 **claim for which the data showed that PacifiCare paid commission to a vendor, which**  
25 **obviously would not occur if the provider had initiated the refund.**

26 **PacifiCare also claimed that it found 1,846 first request letters that were**  
27 **timely sent within 365 days of payment of the claim. PacifiCare produced an Excel**  
28 **spreadsheet that it maintained on these first request letters. That spreadsheet is of**

1 questionable reliability. For instance, PacifiCare's data reflect that a number of these first  
2 request letters were sent the very same day as the claim was paid, or even before the claim  
3 paid date, in one case, 820 days before. Mr. Bugiel admitted that the dates in the field  
4 purporting to be the date that the first request letter was sent may not be accurate; he  
5 testified that those dates may not be the date the letter was sent, but rather the date  
6 additional information was requested from the provider in order to process the claim. In  
7 fact, Mr. Bugiel admitted that he had no evidence that any of the first notification letters  
8 were actually sent on the date of the letter.

9 PacifiCare also produced to the Department around 3,200 pages of  
10 documents that purported to be copies of these first request letters that the company had  
11 located in 2010. When the Department reviewed those letters, it found a number of  
12 discrepancies. For instance, a number of these letters referenced an attachment, but no  
13 attachment was produced. A large number of these letters also failed to include  
14 information required by law, such as the claim number, the name of the patient, the date of  
15 service, and a clear explanation of the basis upon which it is believed the amount paid was  
16 in excess of the amount due.

17 Thereafter, Mr. Bugiel had another search performed for additional  
18 documents associated with the overpayment recovery letters. In February 2011, PacifiCare  
19 produced several hundred more pages of documents related to these letters. These  
20 documents purported to be attachments to some of the overpayment recovery letters, and  
21 they contained some of the required claim information that was missing from the letters.  
22 The Department reviewed these documents, and again found significant discrepancies that  
23 indicated that the purported attachments may not have been attached to the letters. For  
24 example, in some instances, the letters had different account numbers than the  
25 attachments. Mr. Bugiel couldn't explain that discrepancy. Some of the attachments had  
26 different headers and footers than the purportedly corresponding letters. Mr. Bugiel  
27 couldn't explain these discrepancies, either. Also, some of the attachments were dated well  
28 before or well after the date of the purportedly corresponding letters. Mr. Bugiel also

1 couldn't explain why these dates didn't match. The attachments, which contained  
2 information about the date of payment, also revealed that there were 79 additional first  
3 request letters that were sent more than 365 days after payment.

4           Several months later, in April 2011, in an attempt to explain some of these  
5 discrepancies between the letters and the purported attachments, PacifiCare filed a  
6 declaration of Mark Davidson, an employee of another of PacifiCare's overpayment  
7 recovery vendors, the Rawlings Group. Mr. Davidson explained that the reason the  
8 headers and footers on the letters and attachments didn't match was because the  
9 attachment was generated independently of the letter. Mr. Davidson also admitted that in  
10 four instances, the purported attachment that PacifiCare previously represented was  
11 attached to a letter was not the correct document; Mr. Davidson included what he  
12 contended to be the correct attachments. Mr. Davidson also asserted that the Rawlings'  
13 records confirmed that several of the overpayment letters that CDI had questioned Mr.  
14 Bugiel about were in fact generated and sent to the provider on or about the date of the  
15 letters. But in several instances, those Rawlings records that Mr. Davidson relied upon in  
16 his declaration did not reflect that the letters had been sent, only that they had been  
17 printed. When Mr. Davidson was questioned about this on cross examination, he then  
18 contended that the basis for his testimony was that the letters were printed and that it was  
19 Rawlings' standard practice to have printed the attachment and to mail both the letter and  
20 attachment around the same time.

21           Rawlings' records also reflected one instance in which a patient had called  
22 Rawlings to complain about an overpayment demand letter. That patient reported that she  
23 could no longer get treated by her doctor because of Rawlings' overpayment collection  
24 efforts.

25           Mr. Davidson also submitted a supplemental declaration on July 22, 2011. In  
26 that declaration, he admitted that in the course of assembling the Rawlings records that  
27 CDI had requested, he determined that three of the first request letters that had previously  
28 been produced to CDI, and that PacifiCare had represented were sent to providers, had in

1 fact not been sent. In each of those three instances, a first request letter and attachment  
2 had been generated, and they looked identical in format to the other letters and  
3 attachments that Rawlings contends were sent. Mr. Davidson admitted that the existence  
4 of a copy of an overpayment letter and attachment did not prove that they were in fact sent  
5 to a provider. Mr. Davidson also testified that for these three letters, he reviewed  
6 additional Rawlings records, called tracking notes, to verify that the letters had not been  
7 sent. Mr. Davidson did not review the tracking notes for any of the other letters.

8 Based on the data provided, and on PacifiCare's admissions, CDI is now  
9 alleging 1,934 acts in violation based on PacifiCare's sending untimely overpayment  
10 request letters. As discussed below, CDI is also alleging 2,605 acts in violation for  
11 PacifiCare's failing to maintain complete claim files.

12 PacifiCare contends that it implemented corrective action regarding J&R's  
13 error in misidentifying PPO claims as Secure Horizons claims. But according to Mr.  
14 Bugiel, there was no corrective action plan implemented with respect to the sending of  
15 repeated requests for repayment on claims that had already been repaid. There was also  
16 no corrective action plan with respect to sending of second requests in absence of a  
17 documentable first request within 365 days. In fact, there was no internal company  
18 corrective action regarding any of these J&R overpayment issues.

19 Further, PacifiCare's data on the overpayment letters reflected that in a  
20 significant majority of the instances in which the company had sent an untimely first  
21 request overpayment letters, it successfully collected from the provider the full requested  
22 amount. But when PacifiCare determined that these first request letters were untimely, it  
23 did not attempt to return amounts that providers repaid on those claims.

24 PacifiCare contends that the amount at issue with these collection notices was  
25 about \$1 million. PacifiCare also contends that within a few weeks of having been  
26 informed of the provider complaints regarding these overpayment request letters, it  
27 decided to forgo these requests.

28

1                   **PacifiCare also contends that it doesn't offset future claim payments to**  
2 **providers by the amounts PacifiCare contends were overpaid on other claims because its**  
3 **claim system does not have that functionality. It also asserts that it does not seek recoveries**  
4 **of alleged overpayments from members.**

5                   **First, given this information, were these acts knowingly committed or**  
6 **performed with such frequency as to indicate a general business practice?**

7           A.     Yes. PacifiCare is chargeable with knowledge of the correspondence it sends  
8 out. Thus, it knew or should have known whether it had timely sent first notice overpayment  
9 demand letters, and it knew or should have known that thousands of the supposed second notice  
10 letters were untimely sent. By sending those untimely letters, therefore, PacifiCare knowingly  
11 misrepresented pertinent facts.

12           **Q.     Based on the information you have been given, was the issuance, amendment,**  
13 **or servicing of the policy or endorsement inadvertent, as that term is used in section**  
14 **790.035?**

15           A.     No. I saw no evidence that PacifiCare's sending of untimely overpayment  
16 demand letters was an inadvertent issuance, amendment, or servicing of a policy. PacifiCare did  
17 not inadvertently send out these collection letters.

18           **Q.     First, given this background information, do you classify these violations as**  
19 **willful or non-willful?**

20           A.     These are willful violations. PacifiCare willfully — with a purpose and  
21 willingness — outsourced these overpayment recoveries to J&R without adopting and  
22 implementing proper controls to ensure that each overpayment demand was timely. For  
23 instance, PacifiCare's failure to itself confirm or to require its vendor to verify that timely first  
24 notice letters were sent or its failure reflects a willful failure to adopt and implement reasonable  
25 standards for the prompt investigation and processing of claims.

26           **Q.     Now, in light of the facts you have been asked to assume and the factors**  
27 **enumerated in section 2695.12, what penalty would you propose for this category of alleged**  
28 **violations?**

1           A.       First, I have seen no evidence of the existence of extraordinary circumstances  
2 (Reg. § 2695.12, subd. (a)(1)), as that term is defined in the Regulations (Reg. § 2695.2, subd.  
3 (e)).

4           I also did not see evidence that these claims were complex. Nor do I believe that there is  
5 anything complex about ensuring that overpayment recovery letters are not sent more than 365  
6 days after claim payment. (Reg. § 2695.12, subd. (a)(3).)

7           I have not seen sufficient evidence to assess the relative number of claims where the  
8 noncomplying acts were found to exist. (Reg. § 2695.12, subd. (a)(7).) Based on PacifiCare's  
9 data, it appears there were 5,224 total reimbursement requests during this period, so the 1,934  
10 violations reflect a high relative number of noncomplying acts. However, to be conservative, I  
11 will not consider this to be an aggravating factor because I have been given no information on  
12 the total number of claims that the Department reviewed during the relevant period.

13           PacifiCare did implement remedial measures by canceling the overpayment  
14 requests on the claims that it could not find first request letters. (Reg. § 2695.12, subd. (a)(8).)  
15 But PacifiCare failed to take actions to remediate the causes that led to these violations. Mr.  
16 Bugiel's testimony that there were no corrective action plans implemented to address the sending  
17 of repeated requests for repayment on claims that had already been repaid or to address the  
18 sending of second requests in absence of a documentable first request within 365 days is an  
19 aggravating factor. I believe it would be highly effective and not a significant burden to  
20 implement a company policy that, for instance, required verification that first request letter was  
21 timely sent *before* sending second request letters. That PacifiCare successfully collected  
22 reimbursements from providers based on untimely overpayment requests, yet did not attempt to  
23 repay those amounts is also an aggravating factor.

24           For the reasons previously discussed, the existence or nonexistence of previous  
25 violations factor is inapplicable in this case. (Reg. § 2695.12, subd. (a)(9).)

26           As discussed above, the primary harm resulting from untimely reimbursement  
27 requests are the administrative burdens, which is confirmed by the specific facts of these  
28

1 violations. Forcing providers to track down several year old claims and verify the amounts  
2 paid on those claims presents significant and unnecessary administrative burdens. In addition,  
3 I believe there were financial harms from these violations, given the fact that PacifiCare had  
4 collected on a number of untimely requests and did not repay those amounts when it  
5 discovered the requests were untimely. I did, however, credit PacifiCare for canceling its  
6 requests for repayment on those claims that it could not find timely first notification letters.  
7 Though PacifiCare claims it doesn't seek to collect overpaid amounts from members, members  
8 may still be adversely affected, as confirmed by the fact that a patient claims to have been  
9 denied treatment by her doctor. (I am not, however, considering that patient's complaint in my  
10 assessment of harm here because it is not clear that the overpayment request at issue in that  
11 case was untimely.) Overall, this is a slightly aggravating factor.

12 Under the totality of circumstances, I do not believe PacifiCare made a good faith  
13 attempt to comply. (Reg. § 2695.12, subd. (a)(12).) I do credit PacifiCare for quickly  
14 responding to the provider complaints regarding these overpayment demand letters, for ceasing  
15 the sending out of additional overpayment demand letters after being informed of these  
16 problems, and for canceling requests on claims that it could not find a first request letter. But the  
17 company's actions that led to the violations were not taken in good faith. In particular, its failure  
18 to verify that a first request letter was timely sent before sending second request letters is such an  
19 obvious omission, especially when the claims are several years old, that I cannot conclude that  
20 the company acted in good faith. I also believe the company's data it uses to send recovery  
21 requests are unreliable; PacifiCare's witness admitted deficiencies in the data. This is evidence  
22 of bad faith.

23 Issuing 1,934 untimely overpayment demand letters over the course of  
24 approximately five months is a high frequency, but the detriment to the public was not severe.  
25 (Reg. § 2695.12, subd. (a)(12).) This factor is neither aggravating nor mitigating.

26 PacifiCare began sending these untimely requests in January 2008, and was made  
27 aware of these problems by CMA and CDI in mid-2008, and it took some remedial action shortly  
28 thereafter. I believe PacifiCare management should have been aware that it was sending these

1 untimely requests far sooner, however. (Reg. § 2695.12, subd. (a)(13).) Had the company  
2 sought to verify that first letters were timely sent or had the company's claims data been of  
3 sufficient quality, PacifiCare should have detected that these overpayment demand letters were  
4 untimely. As discussed above, while I recognize that PacifiCare took certain remedial measures,  
5 I believe they were insufficient to address the root causes of these violations. This is an  
6 aggravating factor.

7 On balance, I find that these factors represent a set of circumstances that are  
8 aggravating, as compared to the generic violation. I think it appropriate to increase the per  
9 violation penalty by at least 40 percent, from \$3,000 to \$4,200 per act in violation. Therefore,  
10 my aggregate penalty recommendation for this category is \$8,122,800, for these 1,934 violations.

11 **O. PacifiCare's Failure to Maintain Complete Claim Files**

12 **Q. Are you aware of the allegations that PacifiCare failed to maintain complete**  
13 **claim files in violation of law?**

14 A. Yes.

15 **Q. Do failures to maintain complete claim files constitute violations of the**  
16 **Insurance Code or the Fair Claims Settlement Practices Regulations?**

17 A. Yes. The failing to maintain a complete claim file, if committed knowingly or  
18 performed with such a frequency as to indicate a general business practice, may constitute a  
19 violation of Insurance Code section 790.03, subdivision (h)(3), if that failure affects the prompt  
20 investigation and processing of claims. It may also constitute a violation of section 790.03,  
21 subdivision (h)(2), if that failure prevents the insurer from acknowledging and acting reasonably  
22 promptly upon communications with respect to claims. The failure to maintain a complete claim  
23 file also violates Regulation section 2695.3, subdivisions (a) and (b), which require that claim  
24 files contain "all documents, notes and work papers (including copies of all correspondence)  
25 which reasonably pertain to each claim in such detail that pertinent events and the dates of the  
26 events can be reconstructed and the licensee's actions pertaining to the claim can be  
27 determined."  
28

1           **Q. Do you interpret these laws as requiring an insurer to maintain physical**  
2 **claim files that include hard-copies of each of the required documents?**

3           A. No. Insurers may maintain their claim files in hard copy or electronic format.  
4 But the documents required to be maintained in the file must be accessible, legible, and  
5 retrievable within a reasonable time.

6           **Q. As a general proposition, how serious an act in violation of the law do you**  
7 **view it to be when a company fails to maintain complete claim files?**

8           A. In comparison to the range of violations to which section 790.035 applies, I view  
9 this failure as less serious than average. While there is not the same type of per se harm in  
10 failing to maintain a complete claim file as there is in, say, incorrectly denying a claim, which  
11 deprives a claimant reimbursement that is owed, it is still cause for concern. For example,  
12 failing to have a complete claim file may cause a claim to be incorrectly processed or to be paid  
13 untimely. It may also result in increased administrative burdens to claimants who must re-  
14 submit information to insurers multiple times.

15           Further, as reflected in Regulation section 2695.3, maintaining complete claim files is  
16 essential to ensure effective regulation, for CDI examiners must be able to review all materials  
17 reasonably related to claims. Deficiencies in claim files have the potential to significantly  
18 frustrate the regulatory process.

19           **Q. As a general proposition, where do you place this type of violation on the**  
20 **section 790.035 spectrum from zero to either \$5,000 or \$10,000 per act in violation?**

21           A. Consistent with my description of this type of violation as less serious than many  
22 violations of section 790.03, I would put it at 10% of the way from zero to the maximum, or  
23 \$500 per act for non-willful acts and \$1,000 per act for willful acts.

24           **Q. As mentioned earlier, the Department has alleged 2,605 acts in violations**  
25 **based on PacifiCare's failure to maintain complete claim files relating to the overpayment**  
26 **recovery letters.**

1                   **Given the background information for this issue, were these acts knowingly**  
2 **committed or performed with such frequency as to indicate a general business practice?**

3           A.     Yes. PacifiCare is charged with knowledge of the documents it maintains in its  
4 own claim files. Absent evidence that PacifiCare had a reasonable basis to be unaware of the  
5 contents of its files, the company's failure to maintain all relevant documents was knowingly  
6 committed.

7           **Q.     Based on the information you have been given, was the issuance, amendment,**  
8 **or servicing of the policy or endorsement inadvertent, as that term is used in section**  
9 **790.035?**

10          A.     No. I saw no evidence that PacifiCare's failure maintain complete claim files  
11 was an inadvertent issuance, amendment, or servicing of a policy. Again, this failure does not  
12 constitute a servicing of the policy. Further, there was no evidence that any of the missing first  
13 request letters was inadvertently omitted from the relevant claim file.

14          **Q.     Given the background information for that issue, do you classify these**  
15 **violations as willful or non-willful?**

16          A.     I will consider these to be non-willful violations.

17          **Q.     Now, in light of the facts you have been asked to assume and the factors**  
18 **enumerated in section 2695.12, what penalty would you propose for this category of alleged**  
19 **violations?**

20          A.     First, I have seen no evidence of the existence of extraordinary circumstances  
21 (Reg. § 2695.12, subd. (a)(1)), as that term is defined in the Regulations (Reg. § 2695.2,  
22 subd. (e)).

23                   I also did not see evidence that the claims at issue were complex, or that  
24 maintaining complete files for these claims was complex. (Reg. § 2695.12, subd. (a)(3).)

25                   I have not seen sufficient evidence to assess the relative number of claims where  
26 the noncomplying acts were found to exist. (Reg. § 2695.12, subd. (a)(7).) I have not been  
27 given information about how many claim files the Department reviewed during the relevant  
28 period.

1           There are two types of remedial measures that PacifiCare should have taken with respect  
2 to these violations. (Reg. § 2695.12, subd. (a)(8).) First, it should have sought to find the  
3 missing first request letters. I have seen some evidence of remedial measures in that respect. I  
4 credit PacifiCare's searches for these letters as remedial measures to address the deficiencies in  
5 its claim files. Second, PacifiCare should have taken remedial measures to address the cause or  
6 causes its claim files failed to include first request letters. I saw no evidence of such remedial  
7 measures. Even though I consider the lack of this type of remedial measure to be serious, I will  
8 consider this factor to be neither aggravating nor mitigating because of PacifiCare's remedial  
9 measures to find the letters.

10           For the reasons previously discussed, the existence or nonexistence of previous  
11 violations factor is inapplicable in this case. (Reg. § 2695.12, subd. (a)(9).)

12           The harm caused by these violations was significant. (Reg. § 2695.12, subd.  
13 (a)(10).) First, PacifiCare's failure to maintain these first request letters caused PacifiCare to  
14 send out untimely overpayment demand letters. Because those are being charged as separate  
15 violations, however, I will not consider that harm in assessing these violations. These violations  
16 also resulted in significant administrative burdens to the Department. In order to understand and  
17 to reconstruct what PacifiCare did for these claims, the Department was forced to examine  
18 PacifiCare witnesses for multiple days, to analyze multiple PacifiCare's claims databases, and to  
19 review thousands of pages of PacifiCare's documents comprising purported first notice letters,  
20 attachments to these letters, and internal records of a PacifiCare recovery vendor. This appeared  
21 to be a significant effort. Further, there were significant number of discrepancies in PacifiCare's  
22 data and in the documents it produced, forcing the Department to piece together what actually  
23 happened using conflicting information. Mr. Bugiel, the PacifiCare witness designated as the  
24 person most knowledgeable on these issues, was unable to explain many of these discrepancies.  
25 Overall, I saw evidence of an insurer whose processes for maintaining claim files was in  
26 disarray. It produced data or documents purporting to show that first notice letters were timely  
27 sent out; the Department would review them and find discrepancies that the company couldn't  
28 explain; PacifiCare would then produce additional data or documents to explain those

1 discrepancies; but that additional information created even more discrepancies, which PacifiCare  
2 again couldn't explain. These burdens PacifiCare imposed on the Department are precisely what  
3 the Regulations are purposed on avoiding when they require claim files to include all materials  
4 "which reasonably pertain to each claim in such detail that pertinent events and the dates of the  
5 events can be reconstructed and the licensee's actions pertaining to the claim can be  
6 determined." (Reg. § 2695.2, subd. (a).) This is a significantly aggravating factor.

7 Under the totality of circumstances, I do not believe PacifiCare made a good faith  
8 attempt to comply. (Reg. § 2695.12, subd. (a)(12).) I do credit PacifiCare for attempting to  
9 search for the first request letters in mid-2008, but it found only several hundred letters at that  
10 time. The company then stopped searching and didn't resume until around two years later in  
11 2010, in preparation for the testimony of Mr. Bugiel, apparently in an effort to reduce the  
12 number of alleged violations relating to the untimely overpayment demands. After several  
13 rounds of searching, PacifiCare ultimately claimed to have found over 2,000 first request letters  
14 as of mid-2010. These are first request letters that presumably PacifiCare could have, and  
15 should have, found in mid-2008, but it decided to stop searching for them. This is evidence of  
16 not attempting in good faith to comply. Further, PacifiCare's production of claims databases and  
17 documents that contained conflicting information is also evidence of not attempting in good faith  
18 to comply. Instead of dumping data and documents of questionable accuracy and reliability on  
19 the Department and forcing the Department to sort out the information, PacifiCare should have  
20 provided clear, understandable, and reliable information pertaining to these issues, and not  
21 imposed burdens on CDI because the company's claim files were so disorganized.

22 Having 2,605 deficient claim files is a high frequency, and as discussed above,  
23 the detriment to the public was the burden PacifiCare imposed on the Department, which was  
24 considered in the harm factor. (Reg. § 2695.12, subd. (a)(12).)

25 PacifiCare's management was aware that it was unable to locate first request  
26 letters for these claims at least as early as May 2008. (Reg. § 2695.12, subd. (a)(13).) While it  
27 did an initial search for these letters in mid-2008, it is obvious now that that search was  
28 inadequate. As previously discussed, PacifiCare was able to find over 2,000 additional first

1 letters in its 2010 search. It therefore failed to take sufficient remedial actions to find the missing  
2 letters for approximately two years. As I said before, PacifiCare also took no remedial actions to  
3 address the cause of its failure to maintain these claim files. This factor is aggravating.

4 On balance, I find that these factors represent a set of circumstances that are significantly  
5 aggravating, as compared to the generic violation. I think it appropriate to increase the per  
6 violation penalty by at least 50 percent, from \$500 to \$750 per act in violation. Therefore, my  
7 aggregate penalty recommendation for this category is \$1,953,750, for these 2,605 violations.

8 **P. PacifiCare's Failure to Timely Respond to CDI Inquiries**

9 **Q. Are you aware of the allegations that PacifiCare failed to timely provide a**  
10 **complete written response to a CDI inquiry in violation of law?**

11 A. Yes.

12 **Q. Do such failures constitute violations of the Insurance Code or the Fair**  
13 **Claims Settlement Practices Regulations?**

14 A. Yes. The failing to timely provide a complete written response to a CDI inquiry,  
15 if committed knowingly or performed with such a frequency as to indicate a general business  
16 practice, constitutes a violation of Insurance Code section 790.03, subdivision (h)(2), because it  
17 represents a failure to acknowledge and act reasonably promptly upon communications with  
18 respect to claims. It further violates Regulation section 2695.5, subdivision (a), which requires  
19 that "[u]pon receiving any written or oral inquiry from the Department of Insurance concerning  
20 a claim, every licensee shall immediately, but in no event more than twenty-one (21) calendar  
21 days of receipt of that inquiry, furnish the Department of Insurance with a complete written  
22 response based on the facts as then known by the licensee."

23 **Q. As a general proposition, how serious an act in violation of the law do you**  
24 **view it to be when a company fails to timely provide a complete written response to a CDI**  
25 **inquiry?**

26 A. In comparison to the range of violations to which section 790.035 applies, I view  
27 this failure as less serious than the average violation. Like failures to maintain claim files, there  
28 is not the same type of per se harm in failing to timely respond to a CDI inquiry as there is in,

1 say, incorrectly denying a claim, but it is still cause for concern. Failing to timely respond to a  
2 CDI inquiry may delay regulatory review and resolution of a claim that is being appealed by a  
3 member or provider. In that instance, this type of violation would harm a member or provider.  
4 Further, as reflected in Regulation section 2695.5, timely responding to CDI inquiries is  
5 necessary to ensure effective regulation. Delays in responding to CDI inquiries and in providing  
6 documentation and claim files requested have the potential to significantly frustrate the  
7 regulatory process.

8 **Q. As a general proposition, where do you place this type of violation on the**  
9 **section 790.035 spectrum from zero to either \$5,000 or \$10,000 per act in violation?**

10 A. Consistent with my description of this type of violation as less serious than many  
11 violations of section 790.03, I would put it at 10% of the way from zero to the maximum, or  
12 \$500 per act for non-willful acts and \$1,000 per act for willful acts.

13 **Q. Let me describe for you the background of these violations. Please assume**  
14 **the following facts:**

15 **As you are aware, when CDI receives a member or provider complaint**  
16 **against PacifiCare, it requests the claim file and other documentation in order to review**  
17 **the complaint. CDI compliance officers in investigating these complaints against**  
18 **PacifiCare identified 29 instances in which the company failed to provide a complete**  
19 **written response to such a CDI inquiry within 21 days. CDI sent violation letters to**  
20 **PacifiCare notifying the company of each of these violations. PacifiCare did not respond to**  
21 **those letters to contest the violations. PacifiCare also admitted that it failed to respond to a**  
22 **CDI inquiry within 21 calendar days in one instance.**

23 **In early 2007, regulatory complaints against PacifiCare relating to PPO**  
24 **claims increased significantly. Internal PacifiCare documents reflect employees' belief that**  
25 **the increase in regulatory complaints was caused by United's taking over PacifiCare's**  
26 **claims, customer service, membership accounting, and mailroom operations. PacifiCare**  
27 **also admitted that this increase in complaints adversely affected the company's ability to**  
28 **timely and accurately respond to CDI inquiries. In early February 2007, PacifiCare had**

1 **drafted a corrective action plan purporting to ensure that regulatory complaints were**  
2 **researched and that all information requested by CDI is provided within the timeframe**  
3 **noted.**

4 **First, given this information, were these acts knowingly committed or**  
5 **performed with such frequency as to indicate a general business practice?**

6 A. Yes. PacifiCare is charged with knowing the dates it receives inquiries from CDI  
7 and the dates it provides a complete response to CDI.

8 **Q. Based on the information you have been given, was the issuance, amendment,**  
9 **or servicing of the policy or endorsement inadvertent, as that term is used in section**  
10 **790.035?**

11 A. No. I saw no evidence that PacifiCare's failure to timely provide a complete  
12 written response to CDI was an inadvertent issuance, amendment, or servicing of a policy.  
13 There was no evidence that PacifiCare inadvertently sent any of the responses to CDI inquiries.

14 **Q. Given the background information for these violations, do you classify them**  
15 **as willful or non-willful?**

16 A. I will consider these to be non-willful violations.

17 **Q. Now, in light of the facts you have been asked to assume and the factors**  
18 **enumerated in section 2695.12, what penalty would you propose for this category of alleged**  
19 **violations?**

20 A. First, I have seen no evidence of the existence of extraordinary circumstances  
21 (Reg. § 2695.12, subd. (a)(1)), as that term is defined in the Regulations (Reg. § 2695.2, subd.  
22 (e)).

23 I also did not see evidence that the claims at issue were complex, or that responding to  
24 any of the CDI inquiries was complex. (Reg. § 2695.12, subd. (a)(3).)

25 I do not have enough information to assess the relative number of claims where  
26 noncomplying acts were found to exist. (Reg. § 2695.12, subd. (a)(7).)

27  
28

1 I credit the company for implementing remedial actions. (Reg. § 2695.12, subd. (a)(8).)  
2 While I have no evidence that the company's corrective action plan was implemented or was  
3 effective, I will give PacifiCare the benefit of the doubt and assume it was.

4 For the reasons previously discussed, the existence or nonexistence of previous violations  
5 factor is inapplicable in this case. (Reg. § 2695.12, subd. (a)(9).)

6 I saw no evidence that the harm caused by these violations were any different from the  
7 generic violation for failing to respond to CDI inquiries within 21 days. (Reg. § 2695.12, subd.  
8 (a)(10).)

9 Based on the fact that PacifiCare drafted a corrective action plan, I will give PacifiCare  
10 credit for making a good faith attempt to comply. (Reg. § 2695.12, subd. (a)(12).)

11 Failing to respond to CDI requests in 30 instances is a high frequency. In my experience,  
12 insurers rarely fail to comply with this requirement to provide a complete written response to  
13 CDI inquiries within 21 days; that PacifiCare was cited with this frequency is unusual. But  
14 because I saw no evidence that the detriment to the public was severe, I will consider this factor  
15 to be neither aggravating nor mitigating. (Reg. § 2695.12, subd. (a)(12).)

16 I have not seen sufficient evidence to determine when PacifiCare management was aware  
17 or should have been aware of these problems. I do give credit to PacifiCare, however, for having  
18 a corrective action plan set forth in February 2007, and for that reason consider this to be a  
19 mitigating factor. (Reg. § 2695.12, subd. (a)(13).)

20 On balance, I find that these factors represent a set of circumstances that are slightly  
21 mitigating, as compared to the generic violation. I think it appropriate to reduce the per violation  
22 penalty by 10 percent, from \$500 to \$450 per act in violation. Therefore, my aggregate penalty  
23 recommendation for this category is \$13,500, for these 30 violations.

24 **Q. PacifiCare's Failure to Train Claims Agents on the Fair Claims**  
25 **Settlement Practices Regulations**

26 **Q. Are you aware of the allegations that PacifiCare failed to train claims agents**  
27 **on the Fair Claims Settlement Practices Regulations in violation of law?**

28 **A. Yes.**

1           **Q. Do such failures constitute violations of the Insurance Code or the Fair**  
2           **Claims Settlement Practices Regulations?**

3           A. Yes. Regulation section 2695.6 specifically requires all licensees to provide  
4           “thorough and adequate training regarding the regulations to all their claims agents.” (Reg. §  
5           2695.6, subd. (b).) Failing to provide such training, if committed knowingly or performed with  
6           such a frequency as to indicate a general business practice, further constitutes a violation of  
7           Insurance Code section 790.03, subdivision (h)(2), because it represents a failure to adopt and  
8           implement reasonable standards for the prompt investigation and processing of claims.

9           **Q. As a general proposition, how serious an act in violation of the law do you**  
10          **view it to be when a company fails to provide its claims agents training on the Regulations?**

11          A. In comparison to the range of violations to which section 790.035 applies, I view  
12          this failure as very serious. This type of violation may lead to errors in processing claims, which  
13          result in additional violations of law and harm members and providers. Further, I consider the  
14          requirement to train claims agents on the Regulations to be a basic requirement that should not  
15          be difficult to comply with. In general, failure to do so reflects a concerning disregard for  
16          regulatory requirements. However, the seriousness of the violation might depend on whether the  
17          company, for example, simply disregarded the requirement to train or instituted training that was  
18          inadequate; as well as on the responsibilities of the employees whom it failed to train.

19          **Q. As a general proposition, where do you place this type of violation on the**  
20          **section 790.035 spectrum from zero to either \$5,000 or \$10,000 per act in violation?**

21          A. Consistent with my description of this type of violation as very serious, I would  
22          put it at 60% of the way from zero to the maximum, or \$3,000 per act for non-willful acts and  
23          \$6,000 per act for willful acts.

24          **Q. Let me describe for you the background of these violations. Please assume**  
25          **the following facts:**

26                   **Prior to May 2007, claims agents in PacifiCare’s Appeals & Grievances**  
27          **department were not provided training on the Regulations. As of May 2007, there were 14**  
28          **claims agents in that department.**

1                   **In 2007, PacifiCare’s vendor, J&R, maintained a unit that processed appeals**  
2 **from providers who disputed PacifiCare requests for overpayment recoveries. None of the**  
3 **9 claims agents in that unit were provided training on the Regulations.**

4                   **First, given this information, were these acts knowingly committed or**  
5 **performed with such frequency as to indicate a general business practice?**

6           A.     Yes. Because PacifiCare is charged with knowing that its claims agents weren’t  
7 being trained on the Regulations, it knowingly failed to adopt and implement reasonable  
8 standards for the prompt investigation and processing of claims.

9           **Q.     Based on the information you have been given, was the issuance, amendment,**  
10 **or servicing of the policy or endorsement inadvertent, as that term is used in section**  
11 **790.035?**

12          A.     No. I saw no evidence that PacifiCare’s failure to train these claims agents  
13 constituted and inadvertent servicing of the policy.

14          **Q.     Given the background information for these violations, do you classify them**  
15 **as willful or non-willful?**

16          A.     I will consider these to be non-willful violations.

17          **Q.     Now, in light of the facts you have been asked to assume and the factors**  
18 **enumerated in section 2695.12, what penalty would you propose for this category of alleged**  
19 **violations?**

20          A.     First, I have seen no evidence of the existence of extraordinary circumstances  
21 (Reg. § 2695.12, subd. (a)(1)), as that term is defined in the Regulations (Reg. § 2695.2,  
22 subd. (e)).

23                   I also did not see evidence that the claims at issue were complex, or that training  
24 claims agents on the Regulations would be complex. (Reg. § 2695.12, subd. (a)(3).)

25                   The relative number of claims where noncomplying acts were found to exist does  
26 not appear to be applicable to this set of violations. (Reg. § 2695.12, subd. (a)(7).)

27                   I do not have sufficient evidence to assess whether PacifiCare has taken remedial  
28 measures. (Reg. § 2695.12, subd. (a)(8).)

1 For the reasons previously discussed, the existence or nonexistence of previous  
2 violations factor is inapplicable in this case. (Reg. § 2695.12, subd. (a)(9).)

3 The harm caused by these specific violations is greater than that of the generic  
4 violation of failing to train claims agents on the Regulations. (Reg. § 2695.12, subd. (a)(10).)  
5 First, it wasn't the case that PacifiCare attempted to train, but did it inadequately; they failed to  
6 do so completely. Second, failing to train the entire Appeal & Grievances unit and the entire  
7 J&R appeals unit is more serious than failing to train one or a few employees in those units.  
8 Moreover, claims that get appealed are typically more complicated than other claims making  
9 training all the more important. However, I also considered the fact that fewer claims get  
10 appealed, so there may be fewer opportunities for errors. This is an aggravating circumstance.

11 I do not have sufficient evidence to assess whether PacifiCare made a good faith  
12 attempt to comply. (Reg. § 2695.12, subd. (a)(12).)

13 This is a basic requirement that should be easy to comply with, but 23 instances as  
14 an absolute number is probably not a particularly high frequency. I saw no evidence that the  
15 detriment to the public was severe, I will consider this factor to be slightly mitigating. (Reg. §  
16 2695.12, subd. (a)(12).)

17 I have not seen sufficient evidence to determine when PacifiCare management was  
18 aware or should have been aware of these problems, but failed to implement remedial measures.  
19 (Reg. § 2695.12, subd. (a)(13).)

20 On balance, I find that these factors represent a set of circumstances that are slightly  
21 aggravating. I think it appropriate to increase the per violation penalty by 10 percent, from  
22 \$3,000 to \$3,300 per act in violation. Therefore, my aggregate penalty recommendation for this  
23 category is \$75,900, for these 23 violations.

24 **R. PacifiCare's Misrepresentations to CDI**

25 **Q. Are you aware of the allegations that during the MCE, PacifiCare made**  
26 **several misrepresentations to CDI in company responses to referrals in violation of law?**

27 **A. Yes.**  
28

1           **Q. Do misrepresentations to the Department during an examination constitute**  
2 **violations of the Insurance Code or the Fair Claims Settlement Practices Regulations?**

3           A. Yes. Such misrepresentations constitute violations of Insurance Code section  
4 790.03, subdivision (e), which makes it an unfair and deceptive act to make any false statement  
5 or to willfully omit any material fact pertaining to the business of the insurer with the intent to  
6 deceive any examiner. It also violates Regulation section 2695.5, subdivision (a), which  
7 requires that insurers provide in response to CDI inquiries “a complete written response based  
8 on the facts as then known by the licensee.”

9           **Q. As a general proposition, how serious an act in violation of the law do you**  
10 **view it to be when a company misrepresents facts during an MCE?**

11           A. In comparison to the range of violations to which section 790.035 applies, I view  
12 such misrepresentations as acutely serious. Effective regulation depends on the candor of  
13 regulatees. The Department simply does not have sufficient resources to independently verify  
14 every representation made by its licensees; rather, the Department must trust that the claims data  
15 provided by insurers are authentic and not manipulated, must trust that claim files produced  
16 contain all relevant documentation, and must trust that statements made by insurers are true and  
17 do not omit material information. Intentional misrepresentations undermine and frustrate the  
18 regulatory process and cannot be tolerated. Though harm to members and providers may not be  
19 as direct as, say, when a claim is incorrectly denied or is untimely processed, it still obtains,  
20 indeed, in a more pervasive manner as less effective regulation affects all consumers.

21           **Q. As a general proposition, where do you place this type of violation on the**  
22 **section 790.035 spectrum from zero to either \$5,000 or \$10,000 per act in violation?**

23           A. Consistent with my description of this type of violation as acutely serious, I  
24 would put it at 90% of the way from zero to the maximum, or \$9,000 per willful act. (All  
25 intentional misrepresentations would be willful.)

26           **S. PacifiCare’s Failure to Conduct Business in Its Own Name**

27           **Q. Are you aware of the allegations that PacifiCare failed to identify its legal**  
28 **name on letters and EOBs sent to claimants in violation of law?**

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A. Yes.

**Q. Do failures to identify the legal name of the underwriting insurance company on letters and EOBs sent to claimants constitute violations of the Insurance Code or the Fair Claims Settlement Practices Regulations?**

A. Yes. The failure to transact business using the legal name of the underwriting insurance company, if committed knowingly or performed with such a frequency as to indicate a general business practice, constitutes a violation of Insurance Code section 790.03, subdivision (h)(1), because it is a misrepresentation to claimants of a pertinent fact relating to coverage. It further violates section 880, which requires every insurer to conduct its business in this state in its own name.

**Q. As a general proposition, how serious an act in violation of the law do you view it to be when a company fails to conduct business in its own name?**

A. In comparison to the range of violations to which section 790.035 applies, I view this failure as less serious than the average violation. This type of violation may likely result in member and provider confusion and may even prevent a claimant from filing an appeal with the insurer or with the appropriate regulatory agency, both of which are serious concerns.

**Q. As a general proposition, where do you place this type of violation on the section 790.035 spectrum from zero to either \$5,000 or \$10,000 per act in violation?**

A. Consistent with my description of this type of violation as less serious than many violations of section 790.03, I would put it at 5% of the way from zero to the maximum, or \$250 per act for non-willful acts and \$500 per act for willful acts.

**Q. Based on your experience, would 30 violations of this law over an approximately two-year period be a cause for concern?**

A. Yes. Identifying the insurer's name in correspondence with claimants is a basic requirement that should be easy to comply with. I rarely see companies violating this requirement. Citing a company for 30 such violations over that period is very unusual.

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**T. PacifiCare’s Failure to Timely Respond to Claimants**

**Q. Are you aware of the allegations that PacifiCare failed to timely respond to claim-related communications from claimants in violation of law?**

A. Yes.

**Q. Do failures to respond to timely claimants constitute violations of the Insurance Code or the Fair Claims Settlement Practices Regulations?**

A. Yes. The failing to timely respond to claimants, if committed knowingly or performed with such a frequency as to indicate a general business practice, constitutes a violation of Insurance Code section 790.03, subdivision (h)(2), which requires insurers to acknowledge and act reasonably promptly upon communications with respect to claims, and subdivision (h)(3), which requires insurers to adopt and implement reasonable standards for the prompt investigation and processing of claims. It further violates Regulation section 2695.5, subdivision (b), which specifically requires insurers to “immediately, but in no event more than fifteen (15) calendar days” provide the claimant a complete response.

**Q. As a general proposition, how serious an act in violation of the law do you view it to be when an insurer fails to timely provide a complete response to a claimant?**

A. In comparison to the range of violations to which section 790.035 applies, I view this failure as less serious than the average violation. Delays in providing complete responses harm providers and members, and may result in delays in processing claims.

**Q. As a general proposition, where do you place this type of violation on the section 790.035 spectrum from zero to either \$5,000 or \$10,000 per act in violation?**

A. Consistent with my description of this type of violation as less serious than many violations of section 790.03, I would put it at 20% of the way from zero to the maximum, or \$1,000 per act for non-willful acts and \$2,000 per act for willful acts.

1           **U.     PacifiCare’s Failure to Implement a Policy Regarding Recording the**  
2           **Date of Receipt of Claims**

3           **Q.     Are you aware of the allegations that PacifiCare failed to implement a policy**  
4 **for its member appeals department regarding using the correct receipt date of a claim for**  
5 **purposes of calculating interest on late-paid claims in violation of law?**

6           A.     Yes.

7           **Q.     Does the failure to implement a policy regarding recording the correct**  
8 **received date constitute a violation of the Insurance Code or the Fair Claims Settlement**  
9 **Practices Regulations?**

10          A.     Yes. The such a failure, if committed knowingly or performed with such a  
11 frequency as to indicate a general business practice, constitutes a violation of Insurance Code  
12 section 790.03, subdivision (h)(3), because it reflects a failure to adopt and implement  
13 reasonable standards for the prompt investigation and processing of claims. Failing to record the  
14 correct date of receipt of a claim may result in, among other things, the incorrect calculation of  
15 interest due, thereby delaying the correct processing claims. It also violates Regulation section  
16 2695.3, subdivision (b), which specifically requires the insurer to maintain in the claim file  
17 information regarding the date the licensee received any claims or claim-related documents.  
18 Subdivision (a) of that section further requires insurers to maintain in claim files information in  
19 such detail that the dates of the events can be reconstructed and the licensee’s actions pertaining  
20 to the claim can be determined.

21          **Q.     As a general proposition, how serious an act in violation of the law do you**  
22 **view it to be when an insurer fails to implement such a policy?**

23          A.     In comparison to the range of violations to which section 790.035 applies, I view  
24 this failure as very serious. Recording the correct received date of a claim is a fundamental  
25 requirement underlying all the provisions of the Insurance Code and Regulations that seek to  
26 ensure the prompt payment of claims. If an insurer does not have a consistent policy regarding  
27 the recordation of the received date, it calls into question the accuracy of the claims data of that  
28 company.

1 Member appeals departments frequently review claims that need to be reprocessed for  
2 additional payment and for interest. Determining the correct received date is therefore vital to  
3 their function, and the failure to provide such instructions to that entire department is a very  
4 serious problem that has the potential to cause many claims payment errors.

5 **Q. As a general proposition, where do you place this type of violation on the**  
6 **section 790.035 spectrum from zero to either \$5,000 or \$10,000 per act in violation?**

7 A. Consistent with my description of this type of violation as very seriousness, I  
8 would put it at 65% of the way from zero to the maximum, or \$3,250 per act for non-willful acts  
9 and \$6,500 per act for willful acts.

10 **V. PacifiCare's Failure to Conduct a Thorough Investigation**

11 **Q. Are you aware of the allegations that PacifiCare failed to conduct and**  
12 **diligently pursue thorough, fair, and objective investigations of claims in violation of law?**

13 A. Yes.

14 **Q. Does such a failure constitute a violation of the Insurance Code or the Fair**  
15 **Claims Settlement Practices Regulations?**

16 A. Yes. Regulation section 2695.7, subdivision (d), requires that "[e]very insurer  
17 shall conduct and diligently pursue a thorough, fair and objective investigation and shall not  
18 persist in seeking information not reasonably required for or material to the resolution of a claim  
19 dispute." Failing to conduct and diligently pursue a thorough, fair, and objective investigation  
20 of a claim, if knowingly committed or performed with such frequency to indicate a general  
21 business practice, also constitutes a violation of Insurance Code section 790.03, subdivision  
22 (h)(3), because it reflects a failure to adopt and implement reasonable standards for the prompt  
23 investigation and processing of claims. Such a failure also violates section 790.03, subdivision  
24 (h)(5), because it is an instance of not attempting in good faith to effectuate prompt, fair, and  
25 equitable settlements of claims in which liability has become reasonably clear. It also may  
26 violate section 790.03, subdivision (h)(4), because failing to conduct a thorough, fair, and  
27 objective investigation may cause an insurer to fail to affirm or deny coverage within a  
28 reasonable time. It may also constitute a violation of section 790.03, subdivision (h)(1), if the

1 reason for failing to conduct such an investigation is that the insurer is making unnecessary  
2 requests for information; such unnecessary requests are misrepresentations of pertinent facts that  
3 the insurer needs the requested information in order to process the claim at issue.

4 **Q. In investigating member and provider complaints, the Department identified**  
5 **and cited PacifiCare for failing to conduct and diligently pursue investigations of claims.**  
6 **For instance, PacifiCare routinely denied claims based on the possibility of that the**  
7 **treatment may have been provided for a pre-existing condition, even before the company**  
8 **requested medical records that would have been necessary to investigate and determine**  
9 **whether the patient had such a pre-existing condition. In a number of other instances,**  
10 **PacifiCare continued to request from members and providers medical information that**  
11 **was unnecessary and duplicative. PacifiCare also required claimants to re-submit claims**  
12 **multiple times in order to get them processed, in one instance causing an over 10-month**  
13 **delay in getting a claim processed correctly. PacifiCare also incorrectly denied several**  
14 **claims and incorrectly rejected appeals, in many instances not correctly processing the**  
15 **claims until the claimant filed a complaint with the Department.**

16 **As a general proposition, how serious an act in violation of the law do you**  
17 **view it to be when an insurer fails to conduct and diligently pursue a thorough, fair, and**  
18 **objective investigation of a claim?**

19 A. In comparison to the range of violations to which section 790.035 applies, I view  
20 this failure as very serious. The failure to conduct and diligently pursue investigation of claims  
21 results in claims being incorrectly processed, at best, forcing members and providers to submit  
22 additional, unnecessary information, to re-submit claims, to file appeals, to file complaints with  
23 CDI, all of which imposes administrative burdens and delays payment. At worst, failures to  
24 conduct and diligently pursue such investigations result in members and providers being denied  
25 payment altogether, which can also lead patients to be denied medical treatment, because they do  
26 not contest the insurers' incorrect adjudications of the claims, or because they give up appealing  
27 the insurers' determinations on the claims.

1           **Q. As a general proposition, where do you place this type of violation on the**  
2 **section 790.035 spectrum from zero to either \$5,000 or \$10,000 per act in violation?**

3           A. Consistent with my description of this type of violation as very serious, I would  
4 put it at 65% of the way from zero to the maximum, or \$3,250 per act for non-willful acts and  
5 \$6,500 per act for willful acts.

6           **W. PacifiCare’s Misrepresentations of Pertinent Facts**

7           **Q. Are you aware of the allegations that PacifiCare misrepresented pertinent**  
8 **facts regarding insurance coverage to claimants in violation of law?**

9           A. Yes.

10          **Q. Do such misrepresentations violate the Insurance Code or the Fair Claims**  
11 **Settlement Practices Regulations?**

12          A. Yes, they are violations of Insurance Code section 790.03, subdivision (h)(1), as  
13 well as violations of Regulation 2695.4, subdivision (a), which requires insurers to disclose “all  
14 benefits, coverage, time limits or other provisions.”

15          **Q. In general, how would you rate a misrepresentation of a pertinent fact to a**  
16 **claimant?**

17          A. In comparison to the range of violations to which section 790.035 applies,  
18 misrepresentations can range from moderately serious to very serious. The most harmful  
19 misrepresentations are those misinforming consumers about eligibility, coverage and benefits, as  
20 these can lead to patients deferring needed medical care because they believe it will not be  
21 reimbursed. Other misrepresentations may be less immediately harmful, although still  
22 significant, such as misinforming a patient as to his or her financial responsibility, which can  
23 have financial consequences for the consumer. Misrepresentations as to a provider’s network  
24 status can be harmful to the provider, who stands to lose business from insureds who mistakenly  
25 believe the provider is out of network. Such misrepresentations can also be harmful to members:  
26 a member who seeks treatment from an out-of-network provider mistakenly believing the  
27 provider to be in network is likely to bear more financial responsibility than he or she expected;  
28 conversely, a member who is misinformed that a provider is not a PacifiCare contracted provider

1 may avoid that provider, and experiences harm, albeit small, of not being treated by his or her  
2 desired provider.

3 **Q. Where do you place this type of violation on the section 790.035 spectrum**  
4 **from zero to either \$5,000 or \$10,000 per act in violation?**

5 A. It depends on the nature of the misrepresentations, but the minimum would be  
6 30% of the penalty range, or \$1,500 for non-willful acts in violation and \$3,000 for acts in  
7 violation. For misrepresentations with more severe consequences for consumers, I would set the  
8 penalty at 65% of the penalty range, or \$3,250 for non-willful acts in violation and \$6,500 for  
9 acts in violation.

### 10 VIII. Adjustments

11 **Q. Please summarize the penalties you have recommended for each category of**  
12 **violation.**

13 A. The following table lists the categories of violations, the number of acts in  
14 violation, and my recommended unit penalties.

15	16	17	18	19	20	21	22	23	24	25	26	27	28
	<b>Violation Category</b>	<b>Number of Acts in Violation</b>	<b>Penalties</b>	<b>Average Unit Penalty</b>									
	Pacificare's Incorrect Denial of Claims Due to Failure to Maintain COCCs on File	1,799	\$11,031,350	\$6,132									
	Pacificare's Incorrect Denial of Claims Based on an Illegal Preexisting Condition Exclusionary Period	5,314	\$11,808,975	\$2,222									
	Pacificare's Failure to Provide Notice to Providers of Their Right to Appeal to CDI	462,805	\$332,990,250	\$720									
	Pacificare's Failure to Provide Notice to Insureds of Their Right to Request an Independent Medical Review	336,267	\$225,763,350	\$671									
	Pacificare's Failure to Correctly Pay Claims to UCSF	3,124	\$12,798,000	\$4,097									
	Pacificare's Failure to Correctly Pay Claims to UCLA	1,333	\$5,476,875	\$4,109									
	Pacificare's Failure to Respond to Claims Submitted by UCLA	2,405	\$7,215,000	\$3,000									
	Pacificare's Failure to Accurately Pay Claims to Providers other than UCSF and UCLA	78,320	\$384,960,000	\$4,915									
	Pacificare's Failure to Pay Timely Claims	34,997	\$192,483,500	\$5,500									
	Pacificare's Failure to Pay Interest on Late-Paid Claims	5,195	\$8,831,500	\$1,700									
	Pacificare's Failure to Acknowledge Receipt of	56,463	\$79,847,250	\$1,414									

Violation Category	Number of Acts in Violation	Penalties	Average Unit Penalty
Claims			
PacifiCare's Failure to Timely Respond to Provider Disputes	1,510	\$6,644,000	\$4,400
PacifiCare's Illegal Practice of Closing or Denying Claims When Requesting Additional Information	52	\$136,500	\$2,625
PacifiCare's Sending of Untimely Collection Notices on Overpaid Claims	1,934	\$8,122,800	\$4,200
PacifiCare's Failure to Maintain Complete Claims Files	2,605	\$1,953,750	\$750
PacifiCare's Failure to Respond to CDI Inquiry Within 21 Calendar Days	30	\$13,500	\$450
PacifiCare's Failure to Train Claims Agents on the Fair Claims Settlement Practice Regulations	23	\$75,900	\$3,300
Aggregate	994,176	\$1,290,152,500	\$1,298

**Q. Do you believe any further adjustment to these numbers is appropriate?**

A. Yes. I believe an aggregate penalty of \$1,290,152,500 is fully justified by the violations this company has committed. PacifiCare committed over 100 times more violations than any company previously prosecuted, and this is the first case that the Department has found it necessary to prosecute to a conclusion on the merits.

However, where the indicated penalty is this large, I believe it is appropriate to assess that number in light of the company's financial condition and performance. I therefore asked our Financial Surveillance Branch staff to review PacifiCare's financial reports to the Department. In part, this inquiry was intended to assess how much surplus PLHIC could afford to pay without impairing its ability to continue to function as an insurance company. They have advised me that, according to the company's filings with the Department, as of June 30, 2011, PLHIC had \$728.8 million in surplus and \$221.2 million in net written premium. At my request, they performed two industry-standard assessments of capital need. Under one, the net-writing-ratio formula, a company needs \$1 of surplus to support every \$3 in net written premium, which would imply a need for surplus of \$73.8 million. Under the more complex risk-based capital calculation, the company would need \$20.8 million to support its current business volume. Taking the more conservative measure, the \$73.3 million figure, and the \$728.8 million surplus

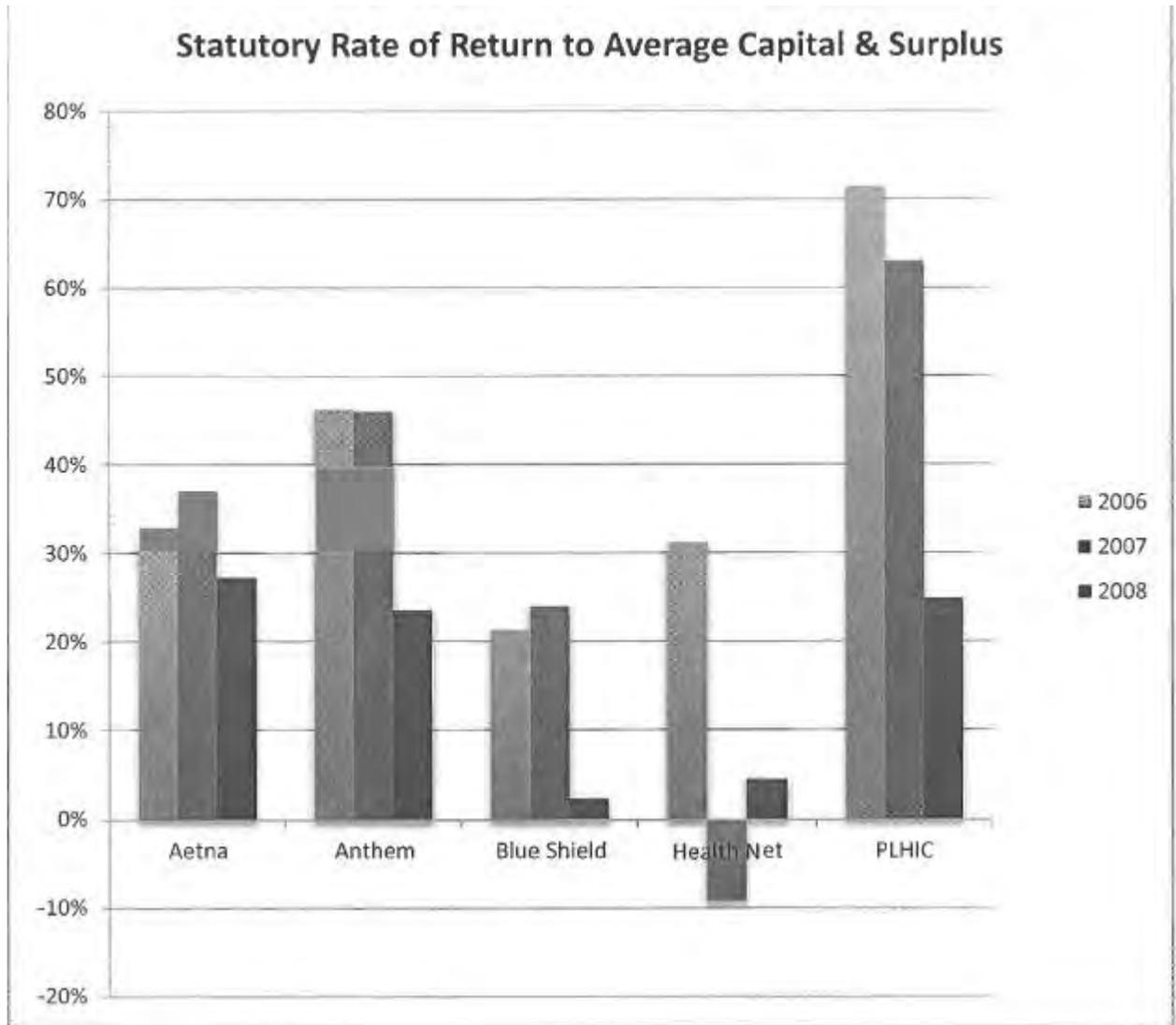
1 number, I conclude that PLHIC could incur aggregate penalties up to \$655 million (\$728.8  
2 million - \$73.8 million) without impairing its ability to support its current operations.

3 I have also examined PLHIC's financial results for the three-year period in which  
4 these violations took place, from 2006 through 2008. The Department views that as the period in  
5 which United took a compliant, successful insurance company and took it out of the California  
6 PPO market. Again, I consulted our Financial Surveillance staff to obtain the relevant figures.  
7 Over those three years, PLHIC reported statutory net income after taxes of \$600.5 million, as  
8 reflected on page 4, line 35, of its amended annual statements filed with the Department.  
9 Dividing each year's after-tax earnings by each year's mean capital and surplus (i.e., the average  
10 of the capital and surplus at the beginning and the end of each year), we see that PLHIC was  
11 enormously profitable during the period of these violations.

	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>Three Years</b>
Net Income	172,039,340	279,561,615	148,919,687	600,520,642
Average Capital and Surplus	240,742,738	443,605,481	597,863,189	427,403,803
Rate of Return on Average Capital & Surplus	71.46%	63.02%	24.91%	46.83%

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17 For context, I compared the same Financial Surveillance data for the companies  
18 having the largest number of covered lives in California. In 2006 through 2008, the four  
19 companies having the largest number of insured lives were Anthem Blue Cross, Blue Shield,  
20 Aetna, and Health Net. In 2006 PacifiCare was number five. In 2007 that position went to  
21 Nationwide, and in 2008 to United. For comparison purposes, I chose the consistent top four  
22 firms. Exhibit \_\_\_\_\_ E shows these four firms' annual returns, plus those of PLHIC and United.  
23 As a group, the top four were significantly less profitable than PLHIC, averaging an 24.34%  
24 return versus PLHIC's 47%. (I consider exclusion of United from this calculation particularly  
25 appropriate, since, as implied by the word "synergies," United's profits can be expected to have  
26 shared the cost-cutting benefits at issue here.) PLHIC's return on capital and surplus was two  
27 times higher than the other four companies. The four companies' results are compared to  
28 PLHIC's in the graph, below.

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These figures indicate that during the period of these violations, PLHIC was realizing robust, above-average profits.

In light of these figures, I think it is appropriate to reduce the aggregate penalty to an amount that may well be less than indicated by the category-by-category analysis of the violations but is still sufficient to achieve deterrence and to punish the very serious course of conduct that created the violations, but that more closely corresponds to the company's financial condition and results. Given these objectives, I recommend the aggregate penalty be reduced to \$325 million. This figure represents approximately half of the company's excess surplus, the

1 amount by which its present surplus exceeds the level required by the risk-based capital  
2 calculation. It also corresponds to a little over half of PLHIC's profits during the violation  
3 period. While this is a large reduction from the \$1,290,152,500 based on a category-by-category  
4 application of the penalty regulations, it is still an amount that I judge to be sufficient to achieve  
5 deterrence and punishment. It would reduce PLHIC's three-year profit by more than half, while  
6 leaving it a statutory return more than twice what its main competitors earned during the same  
7 period. It would leave the company more than enough surplus to support its present business  
8 volume and to substantially increase its writings if it should so desire.

9 I want to emphasize that the Department does not, as a general matter, consider a  
10 licensee's surplus or profits as an absolute limit on penalties. It is possible for an insurer to  
11 commit violations that justify penalties in excess of its profits. In this case, however, a penalty  
12 of \$325 million is appropriate punishment and should serve as a salutary deterrent. I also want to  
13 emphasize that this reduction recognizes that PLHIC is the first company to be held accountable  
14 for so many acts in violation. In the future, companies should know they cannot expect to obtain  
15 similar first-time treatment.

16 I also want to emphasize that, while this \$325 million may be viewed as a reduction  
17 of nearly 75% of the indicated penalty, I have arrived at this figure by assessing an appropriate  
18 dollar amount, not by selecting the percentage reduction. This adjustment is specifically made to  
19 accommodate the effect of the aggregate penalty on PLHIC in the context of its financial  
20 condition and operations and taking into account the amount required to deter the overall course  
21 of conduct. In other words, had the number of violations and my analysis of the application of  
22 the regulations to those violations led me to a \$325 million aggregate penalty in the first  
23 instance, I would, upon assessment of the information discussed here, have decided no further  
24 reduction was appropriate.

25 **Q. How have you arrived at the conclusion that an aggregate penalty of at least**  
26 **this amount is necessary to achieve the purpose of deterring future violations?**

27 A. Yes. My assessment of the need for deterrence is based in part on my years of  
28 experience with our enforcement program. The Department has consistently settled enforcement

1 actions without taking them to hearing and a decision on the merits. While it is generally in the  
2 public interest to settle cases, such settlements inevitably reflect the parties' assessment of the  
3 likely result if there is no settlement. In negotiations over penalties, the carriers and their counsel  
4 have been well aware that the Department has never pursued a case about claims practices to a  
5 final administrative decision. Like any settlement negotiation, the strength of the parties'  
6 positions and the eventual outcome of the negotiation will depend on the parties' respective  
7 beliefs about what would happen if the case does not settle. That fact has sometimes limited our  
8 ability to obtain agreements to penalties commensurate with the gravity of the violations.

9 I have reviewed the testimony of the two sides' expert economists, Dr. Henry  
10 Zaretsky and Dr. Daniel Kessler, and found a key point of agreement between them to ring true  
11 in my experience. Both economists testified that a penalty, to achieve deterrence, must reflect  
12 the violator's assessment of the likelihood that violations will be detected and successfully  
13 prosecuted. I understand that the formulas each economist sponsored will not be employed in  
14 this case and that there is no need to come up with a value for what they each called *P*. But the  
15 underlying reality they both testified to, that the lower the likelihood of detection and  
16 enforcement the higher the penalty must be, is confirmed by my experience and should inform  
17 the penalty decision in this case. And any assessment of the a priori probability of detection and  
18 enforcement grounded in the actual history of our enforcement program must lead to the  
19 conclusion that a company that committed a very large number of violations is very unlikely to  
20 be penalized in an amount commensurate with those acts. I understand PacifiCare has  
21 emphasized here the magnitude of past settlements, which I take as confirmation that companies  
22 doubt that large numbers of serious violations will result in correspondingly large penalties.

23 Many of the violations found in this case appear to have been the product of  
24 PLHIC's owners placing the pursuit of synergies for Wall Street above expressed concerns for  
25 operations, and others appear to have occurred in a culture of attention to profits and indifference  
26 to compliance. A case can certainly be made for a much larger aggregate penalty that does not  
27 allow PLHIC's owners to reap the full extent of the profits they sowed in the violations.

1           The need for insurers to take seriously the possibility of enforcement resulting in  
2 substantial penalties is more important now than in the past, as this case illustrates. Some  
3 insurance markets have become quite concentrated, in part from mergers and acquisitions  
4 purportedly justified by the pursuit of reduced costs. We know from the record here that  
5 acquiring companies view themselves as able to achieve huge savings, all the more if  
6 consolidation is pursued in haste, still more if corners are cut. If future companies pursuing the  
7 kinds of savings United sought here believe that any violations occurring in the process will be  
8 met with penalties that are well below the profits to be realized, hasty and careless practices will  
9 be seen as good business practices and deterrence will not have been achieved.

10           If the decision in this case results in a penalty of the magnitude I am  
11 recommending, then I believe deterrence will have been achieved for future companies in similar  
12 positions and the public interest will have been served.

13           **Q. Case law says that penalties should be “large enough to hurt” in order to**  
14 **achieve their objectives. Do you believe that an aggregate penalty of \$325 million satisfies**  
15 **this requirement?**

16           A. Yes. While the penalty is relatively low in comparison to the financial measures  
17 for this company that I have cited, I believe that management will find a \$325 million penalty  
18 appropriately painful.

19           **Q. Do you have any evidence, beyond your experience in dealing with insurers**  
20 **over nearly 20 years, to substantiate your belief that insurers do not expect the Department**  
21 **to pursue penalties to a litigated conclusion?**

22           A. Yes. I took note of three exhibits Dr. Zaretsky attached to his testimony, marked  
23 as Exhibits 1082B, 1082C, and 1082D. These three documents contain, respectively, United  
24 management’s internal assessment of the low probability of large penalties from the filing of the  
25 accusation in this case, UHG’s 10-K disclosure minimizing the likelihood of large penalties, and  
26 an investment advisor’s opinion to roughly the same effect.

27           In addition, I have been aware for some time of statements made by  
28 representatives of the law firm representing PLHIC in this case to the effect that the Department

1 can be expected to settle violations detected in market conduct examinations. For instance,  
2 attached as Exhibit F is a copy of a PowerPoint presentation given in 2009 by one of  
3 PacifiCare’s lawyers to an industry group entitled “How to Survive a California DOI Market  
4 Conduct Examination.” On slide 49 the presenter notes that “Experience shows settlement much  
5 more likely than formal hearing” and notes that the resolution usually involves remediation, may  
6 require payment of enforcement costs, and “May or may not involve fine.” I take these  
7 statements, which are consistent with my experience dealing with companies and their counsel in  
8 negotiations, to reflect the industry perception that the violations that are detected and become  
9 the subject of a filing may well be resolved without any penalty. I do not fault the lawyers for  
10 making these statements, which are based on past practice, but to me such statements underscore  
11 the need to establish that widespread violations of law can and will be dealt with effectively.

## 12 IX. Summary

13 **Q. Please summarize your final penalty recommendation.**

14 A. I have recommended reducing the aggregate penalty of \$1,290,152,500 arrived at  
15 by category-by-category assessment of the acts in violation of the law and the regulatory  
16 principles that apply to them, to \$325,000,000. The average penalty per act in violation is  
17 \$326.90. This represents my final penalty recommendation.  
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# EXHIBIT A

TONY CIGNARALE, J.D., AIC  
Post Office Box 3456  
Manhattan Beach, CA 90266  
(310) 346-3451

**WORK EXPERIENCE:**

*California Department of Insurance*      Los Angeles, California      (April 1992 to Present)

Deputy Insurance Commissioner, Consumer Services & Market Conduct Branch – (September 2007 - To Present) - Direct the statewide activities of the Consumer Services and Market Conduct divisions, with a staff of 160 insurance professionals. The Consumer Services Division investigates consumer complaints and inquires relating to all lines of insurance, including automobile, homeowners and health insurance issues. The Market Conduct Division conducts on-site examinations of insurer claims, rating and underwriting practices. Represent the department at legislative investigatory hearings on many consumer issues. Coordinate disaster response for the Department, which includes community outreach to public officials and conducting insurance recovery forums for survivors. Provide expert consultation to the Insurance Commissioner on highly complex and sensitive insurance and regulatory matters.

Chief, Consumer Services Division – (November 2001 - September 2007): Directed the statewide activities of the Consumer Services Division with a staff of 100 insurance professionals. Directly oversaw the Department's consumer complaint investigation units, consumer hotline call-center that responds to insurance related questions and inquiries, and the Consumer Education & Outreach Bureau, which develops informational guides and participates in consumer outreach programs. Co-chair of the Department's Fair Claims Settlement Practices Task Force. Coordinated legislative analyses relating to consumer issues and represented the department at legislative hearings. Coordinated Disaster Response for the Department. Earned the Commissioner's Leadership & Teamwork Award in 2004.

Supervising Compliance Officer – (October 1999 - November 2001) Supervised and trained a staff of seven Associate Compliance Officers in the investigation of consumer complaints. Handled complex, high profile and sensitive claim projects presented to the insurance commissioner's office. Trained all claims staff on the Fair Claims Settlement Practices Regulations. Served as special consultant to the Deputy Commissioner on consumer and regulatory issues. Earned the Commissioner's Superior Accomplishment Award in 2001.

Associate Compliance Officer - (April 1992 - October 1999) Analyzed complex claim coverage issues to determine insurance company compliance with the insurance contract, the California Insurance Code and the Fair Claims Settlement Practices Regulations. Earned the Commissioner's Award for Excellence or Superior Accomplishment Award in 1994, 1995, and 1998.

*Thriftco Insurance Company*      Los Angeles, California      (Aug. 1988 to Nov. 1991)

Senior Claims Analyst / Supervisor - Audited claim files for the implementation of more effective policies and procedures. Researched and responded to all significant inquiries from consumers, attorneys, agents, consumer groups and the Department of Insurance. Decided all claims coverage issues. Developed the defense for, and appeared in, all small claims court cases. Formed and supervised a fraud investigation unit within the company. Supervised a staff of seven automobile claims adjusters.

**TONY CIGNARALE, J.D., AIC**  
Post Office Box 3456  
Manhattan Beach, CA 90266

**WORK EXPERIENCE:** (Continued)

Claims Consultant - Hired by President of company to develop and implement a strategy to resolve complaints and lawsuits involving a major customer relations/regulatory crisis. Performed substantial fieldwork, including court appearances. Successfully defended more than 95% of all small claims court actions filed against the company.

National Autoplan                      **New York - San Francisco**                      **(June 1985 to Aug. 1988)**  
Claims Manager - Established procedures for the company's automobile insurance claims operation. Recruited, trained and managed a staff of 25 claims supervisors, adjusters, appraisers, and support personnel. Investigated all suspected fraud cases and responded to all Department of Insurance inquiries. Monitored litigated claims and appeared in all Small Claims Court actions for the company.

Assistant Director of Customer Relations - Duties included analyzing consumer inquiries at all levels within the company, coordinating their resolution, and making recommendations to management concerning more effective systems and procedures.

Material Damage Adjuster - Adjusted caseload of auto physical damage claims. Evaluated all total loss claims and processed all salvage.

**EDUCATION:**

*William Howard Taft University, School of Law* - (1999) Juris Doctor (J.D.) Degree. Admitted to the State Bar of California in June 1999.

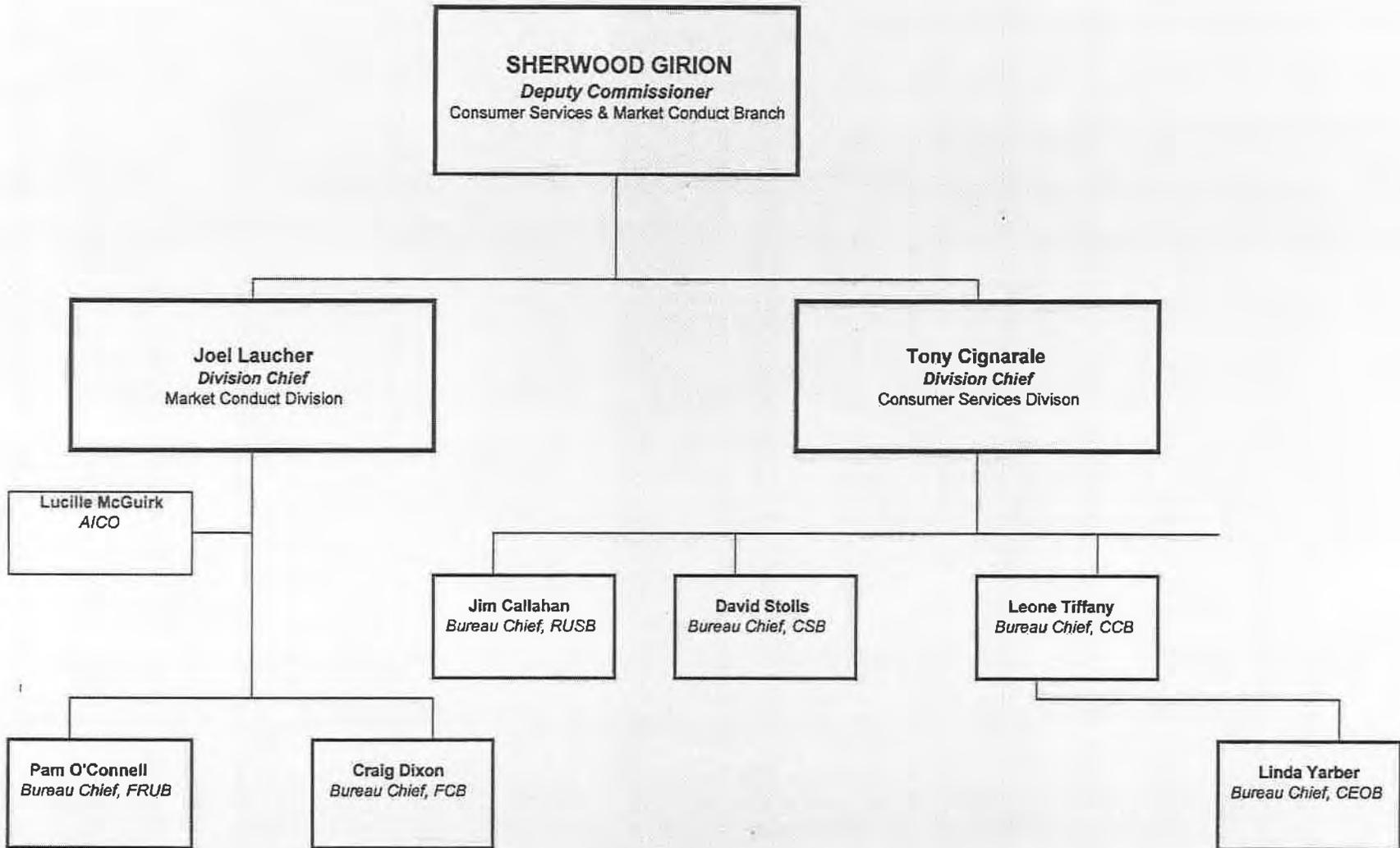
*Insurance Institute of America* (1994) - Associate in Claims (AIC) designation.

*American Educational Institute* (1999) - Casualty Claims Law Specialist designation (CCLS).

*Clarkson University*, Potsdam, New York (1985) - Bachelor of Science in Management with a concentration in Management Information Systems.

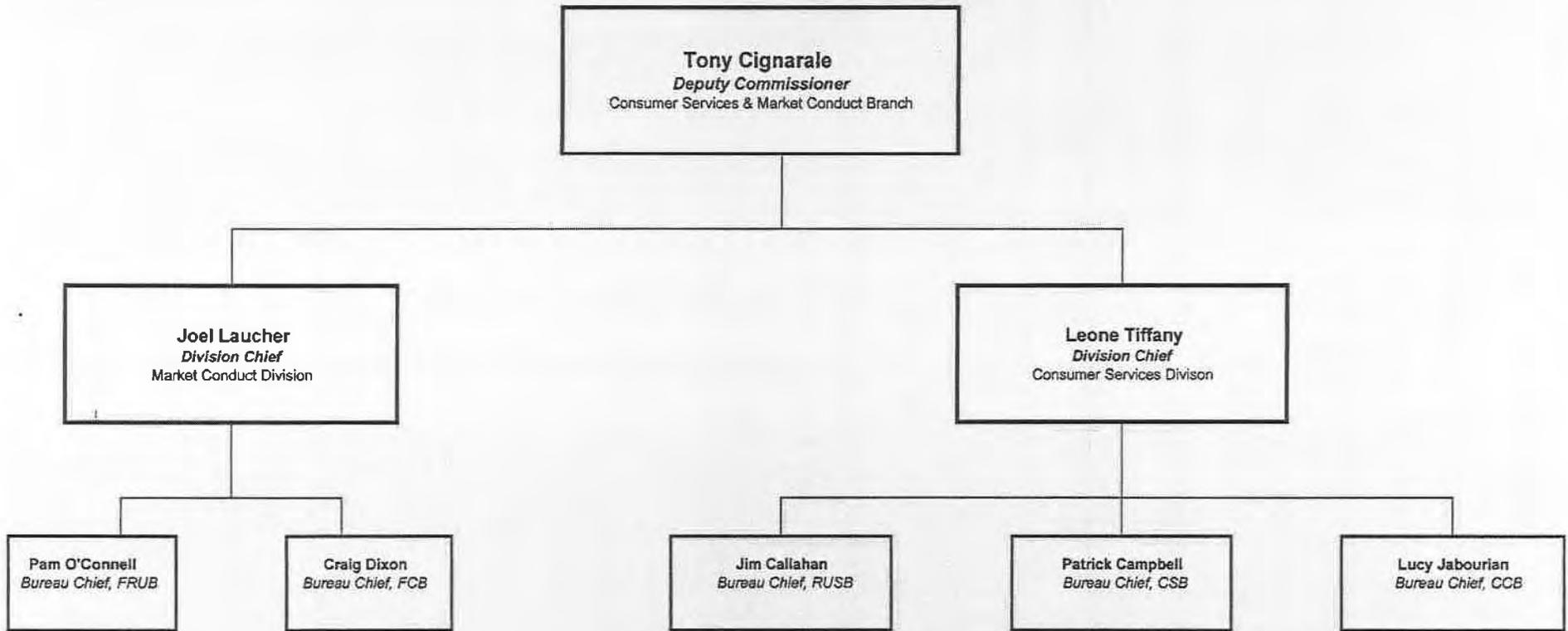
# **EXHIBIT B**

**CSMCB APRIL 2007 ORGANIZATION CHART**



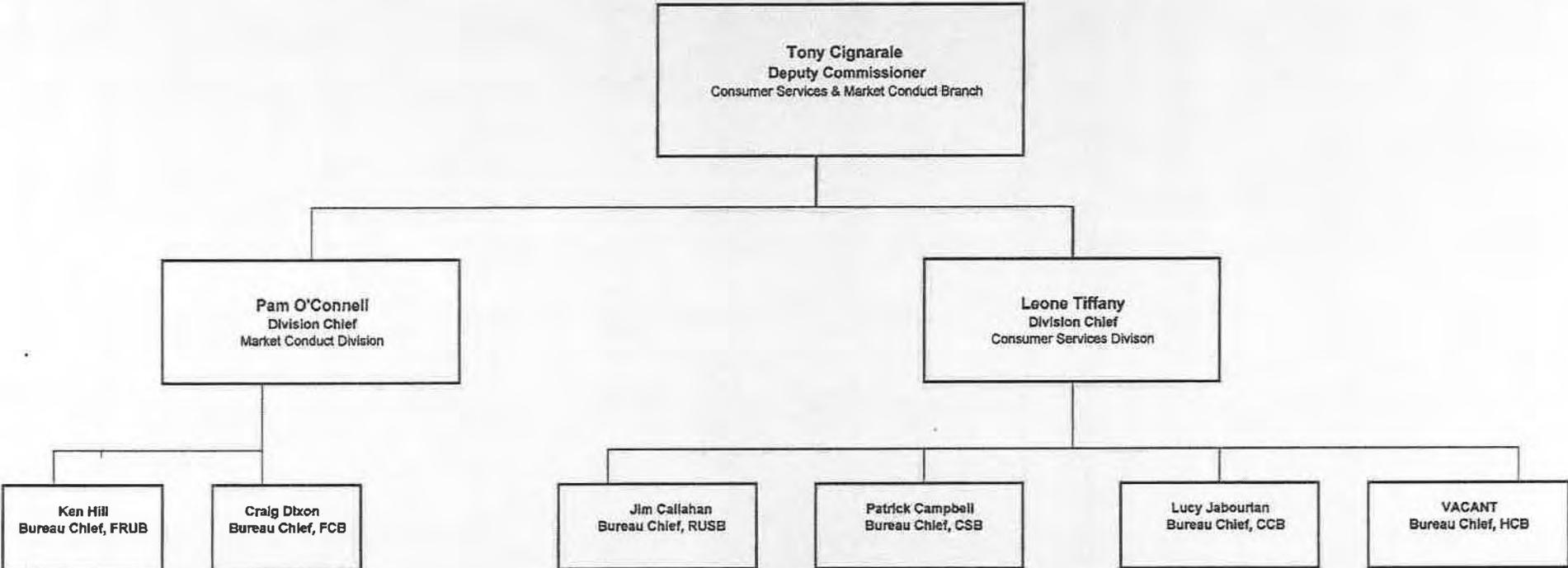
# EXHIBIT C

**CSMCB NOVEMBER 2008 ORGANIZATION CHART**



# EXHIBIT D

**CSMCB OCTOBER 2011 ORGANIZATION CHART**



# EXHIBIT E

Comparison of Statutory Returns, PLHC Vs. Aetna, Anthem, Blue Shield, Health Net, United  
Page 4 of the Annual Statement

Company	Line	Descriptions	2006	2007	2008	Total
Aetna Life Ins Co	35	Net income (net gain from operations after dividends to policyholders plus net realized capital gains or (losses))	981,016,374	1,163,187,447	951,199,372	3,095,403,193
	36	Capital and surplus, December 31, prior year	2,915,227,112	3,037,202,151	3,239,164,424	9,191,593,687
	55	Capital and surplus, December 31, current year	3,037,202,151	3,239,164,424	3,743,546,890	10,019,913,465
	A	Average Capital & Surplus (Prior & Current Years)	2,976,214,632	3,138,183,288	3,491,355,657	9,605,753,576
		Rate of Return on Average Capital & Surplus (Line 35/A)	32.96%	37.07%	27.24%	32.22%
Anthem Blue Cross Life & Hlth Ins Co	35	Net income (net gain from operations after dividends to policyholders plus net realized capital gains or (losses))	329,643,835	380,881,725	194,507,965	905,033,525
	36	Capital and surplus, December 31, prior year	662,773,412	762,072,948	892,350,929	2,317,197,289
	55	Capital and surplus, December 31, current year	762,072,948	892,350,929	760,113,421	2,414,537,298
	A	Average Capital & Surplus (Prior & Current Years)	712,423,180	827,211,939	826,232,175	2,365,867,294
		Rate of Return on Average Capital & Surplus (Line 35/A)	46.27%	46.04%	23.54%	38.25%
Blue Shield of CA Life & Hlth Ins Co	35	Net income (net gain from operations after dividends to policyholders plus net realized capital gains or (losses))	23,901,472	22,596,923	2,967,197	49,465,592
	36	Capital and surplus, December 31, prior year	141,329,972	82,639,425	105,443,764	329,413,161
	55	Capital and surplus, December 31, current year	82,639,425	105,443,764	138,486,888	326,570,077
	A	Average Capital & Surplus (Prior & Current Years)	111,984,699	94,041,595	121,965,326	327,991,619
		Rate of Return on Average Capital & Surplus (Line 35/A)	21.34%	24.03%	2.43%	15.08%
Health Net Life Ins Co	35	Net income (net gain from operations after dividends to policyholders plus net realized capital gains or (losses))	61,712,732	-19,954,359	14,086,156	55,844,529
	36	Capital and surplus, December 31, prior year	191,551,738	203,499,724	233,579,544	628,631,006
	55	Capital and surplus, December 31, current year	203,499,724	233,579,544	368,802,303	805,881,571
	A	Average Capital & Surplus (Prior & Current Years)	197,525,731	218,539,634	301,190,924	717,256,289
		Rate of Return on Average Capital & Surplus (Line 35/A)	31.24%	-9.13%	4.68%	7.79%
UnitedHealthcare Ins Co	35	Net income (net gain from operations after dividends to policyholders plus net realized capital gains or (losses))	2,195,076,258	2,290,321,537	1,867,011,290	6,352,409,085
	36	Capital and surplus, December 31, prior year	1,841,194,312	2,464,265,605	3,104,865,053	7,410,324,970
	55	Capital and surplus, December 31, current year	2,464,265,605	3,104,865,053	2,821,568,928	8,390,699,586
	A	Average Capital & Surplus (Prior & Current Years)	2,152,729,959	2,784,565,329	2,963,216,991	7,900,512,278
		Rate of Return on Average Capital & Surplus (Line 35/A)	101.97%	82.25%	63.01%	80.41%
		Simple Average ROR	46.76%	36.05%	24.18%	34.75%
		Simple Average ROR Excluding United	32.95%	24.50%	14.47%	23.34%
PLHC	35	Net income (net gain from operations after dividends to policyholders plus net realized capital gains or (losses))	172,039,340	279,561,615	148,919,687	600,520,642
	36	Capital and surplus, December 31, prior year	147,211,695	334,273,792	552,937,169	1,034,422,656
	55	Capital and surplus, December 31, current year	334,273,781	552,937,169	642,789,209	1,530,000,159
	A	Average Capital & Surplus (Prior & Current Years)	240,742,738	443,605,481	597,863,189	1,282,211,408
		Rate of Return on Average Capital & Surplus (Line 35/A)	71.46%	63.02%	24.91%	46.83%

# EXHIBIT F

# How to Survive a California DOI Market Conduct Examination

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**AICP - Western Chapter**

Thursday, March 5, 2009  
San Francisco, CA

## Presenter

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**Elizabeth Tosaris  
Sonnenschein Nath & Rosenthal LLP**

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# Roadmap to Today's Discussion

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- Introduction
- Avoiding Market Regulation Scrutiny
- Preparing for Market Regulation Review
- Enduring the Market Conduct Exam
- Resolving Regulator Criticisms
- Lessons Learned
- Questions and Answers

# Chapter One

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## AVOIDING MARKET REGULATION SCRUTINY



## California Department Market Conduct Exam Cycle

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- Exams may be conducted as often as Commissioner deems appropriate, but not less frequently than once every 5 years
- “Exam” not defined
  - Insurers often grouped by holding companies
  - An examination of procedures (v. claim or underwriting files may suffice) especially, if particular company write little or mainly commercial lines business
  - Exam can be desk audit or on site

## **Evolving Approach to Market Regulation**

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- **NEW TOOLS** – NAIC has developed new tools and procedures for identifying entities that may have compliance problems.
- **TARGETING** – Includes a series of tightly-focused questions that concentrate regulator attention on common “problem areas.”
- **SHARING** – NAIC programs to evaluate and share data reported to the states or the NAIC.

## Every Insurer is Scrutinized...

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### NAIC Process: Two Tiers of Review:

- **Tier 1** – Prioritization Tool
  - + General Level 1 Market Analysis
  - >> **Identify Outlier Companies**
- **Tier 2** – Targeted Level 2 Market Analysis
  - + Continuum of Regulatory Responses
  - >> **Could include market conduct exam**

## Tier 1(A) - Prioritization Tool

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- Proprietary program that uses:
  - Financial data
  - Market conduct exam data
  - Complaint data
  - Other information
- Company is not aware when the tool is employed and is not informed of the results.
- Tool is deployed at least once per year.
- As the tool accumulates more data, companies should expect that it will be refined and put to further uses.

## Tier 1(B) – Market Analysis Level 1

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Prioritization results are considered and insurers are subjected to further generalized analysis to identify and target outlier issues.

- Company still not notified of this analysis.
- States are hiring specialized Market Analyst staff – reducing number of field examiners
- Data download requests of insurers
  - > Special considerations for data requests include confidentiality, violation allegations, maximization of potential penalties.

## Level I Review – Red Flags

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- Acquisition by company already in regulator's sights.
- Add officers/directors with history of regulatory issues.
- Regulatory issues in other states.
- Poor financial results or high loss ratios.
- Complaints – consumer, provider, competitor.
- Recent market conduct exam findings.
- Dramatic fluctuations in premium.
- IRIS ratios.
- Competition issues.
- Litigation – class action, individual plaintiff, regulatory.

## 12/08 Refinements to Level 1 Analysis Questions

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- Changes in the company's officers, directors or trustees as reported in the company's last three years of Financial Annual Statements
- Whether there have been more than three examinations of the company commenced in the last twelve months, (and also an analysis of the company's patterns of exam triggers, exam types, areas of examination and status of exam for all exams during the last five years)
- More refined review of company's direct written premium now reflects:
  - LOB-specific information
  - National and state-specific premium information
  - 5 years' worth of premium data

## **Tier 2 – Market Analysis Level Two and More...**

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1. Market Analysis Level 2: Individualized analysis of companies with red flags from earlier review.
  - **Company generally notified of this analysis through data requests.**
  - **Every state makes its own decision whether to continue to a Level II Analysis.**
  - **Results could be the genesis of a targeted exam by one or more regulators.**
2. Continuum of Regulatory Responses: A high score on the second tier review can lead to further regulatory action, including a targeted market conduct examination.
  - **Goal is for state to take the least intrusive path to resolving the regulatory issue.**

## **Avoiding Scrutiny - Fly Under the Radar...**

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- **Keep Consumer Complaints Low**
  - Fight non-justified complaints
  - Fight compounded violation counts
- **Be Timely and Complete on Other DOI Fronts**
  - Rate filings
  - Financial filings
  - Licenses
  - Corporate filings
- **Resolve Other State Issues**
  - NAIC data sharing – RIRS
  - State exam report sharing
  - NAIC multi-state teleconferences

## Flying Low...

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- **Unavoidable Issues**
  - Company financial problems
  - Company mergers and acquisitions
  - Industry investigations by DOIs
  - Negative media attention to industry
    - » Separate industry issues from company acts

## **Steering the Market Analysis Away from Exam**

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### **To Avoid a Discretionary Exam, Seek to Convince State Regulators that an Exam is Not Needed:**

- Be proactive when responding to inquiries.
- Use all available intelligence gathering resources to understand specifics of regulator concern.
- Develop messaging on all points to convey to the regulators.
- Identify situations in which issues are already known, negating need for an exam.

## Chapter Two

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### PREPARING FOR THE MARKET CONDUCT EXAM



## Analyze Internal Needs for Exam

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- Logistics
  - Staff availability and assignments
  - Availability of exam materials
  - Areas of potential regulatory exposure
- Assessment Tools
  - Pre-exam internal audit
  - Pre-review of manuals and files

## Assemble the Company Team

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- Persons knowledgeable about insurer's practices, files, and recordkeeping:
  - Legal/Compliance Expertise
  - Government Relations/Trade Group Liaison
  - Public Relations
    - » With employees and agents
    - » With customers
    - » With public in general
  - Information Technology – data management expert
- Persons with decision-making authority

# California Department Org Chart

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- Consumer Services & Market Conduct Branch
  - Consumer Services Division
  - Market Conduct Division
  
- Market Conduct Division
  - Field Claims Bureau (LA)
    - » Examiners
  - Field Rating & Underwriting Bureau (Sac'to)
    - » Examiners

## Communicate with the Examiners

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- **Influence the timing and location** of exam.
- **Learn the boundaries** of the exam (e.g., What information will be requested? How long will the exam take?).
- **Address logistical needs** (e.g., How many examiners will be on site?).
- **Make any requests** the company has in advance (e.g., numbering of criticisms/referrals to avoid later confusion).

## Company Exam Team Musts

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- Hold regular meetings among team members to discuss exam issues.
- Develop a “Wish List” for how the exam will be conducted.
- Introduce contact people, products, and company compliance efforts.
- Develop messaging around any known compliance issues.

## What to Ask the Examiners

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- Confidentiality: Determine what information or documents will be deemed confidential by regulators.
- Findings: Establish how and when examiners will share their findings before the exam report is drafted.
- Meetings: Schedule periodic meetings.
- Exam Conclusion: Schedule exit interview.
- Seek as much information from examiners as possible.

## Consider a Pre-Review of Exam Files

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- Identify weaknesses in file completeness before examiners criticize company recordkeeping and timeliness.
- Gain a “heads-up” idea of what examiners will find.
- Focus on prior exam findings (same state, other states).
- Focus on emerging industry issues.
- California does not recognize a privilege for “self-audits”.

## Research Your Examiner

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- Canvas others
  - Prior examinees
  - Professionals in field
  - Other examiners
- Identify strengths/weaknesses and areas of knowledge
- Identify examination style

## Maximizing Coordinator Effectiveness

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- Use the Company Coordinator as the **control point** for **all communications** with the examiners:
  - Including communications both to and from the examiners.
- Provide the Coordinator with adequate **resources** in staff and time to be able to:
  - Keep detailed exam records.
  - Follow up promptly on exam inquiries and criticisms.
- Give the Coordinator **authority** to act and ready **access** to the exam management team and interested executives.

## Regulator Expectations for Exam Preparation...

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- Access upon arrival – computer and paper files.
- Complete information in the files and in the claims or underwriting manuals.
- Clear identification of the location of exam materials – to set timelines and logistics.
- Helpful explanation of company differences from examiner requests for data.
  - Data field differences
  - Company terminology

# Chapter Three

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## ENDURING THE EXAM



# Introductory Meeting Basics

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- Establish a rapport.
- Explain company systems and procedures.
- Provide a contact information sheet to examiners so they know who to contact at company and where to send mail.



## Educate the Examiners

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- Start out by showing you are helpful, professional, knowledgeable, and committed to customer service will be very important as the exam progresses.
- Consider a brief a product lesson.
- Assume examiners have very diverse levels of knowledge.

## Address Known Issues Up-Front

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- What have other states previously objected to about the company's practices?
  - Past exam reports
  - Complaints
  - Other (informational comments to company, information from plaintiff's bar, etc.)
- What has CDI communicated regarding the issues for this exam?
- Do recent complaints to CDI have common themes?

## During the Exam...

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- **If you know you have a problem:**
  - Acknowledge it, but
  - Explain what the company has already done to fix it (at individual file and general practice levels).
- **If you do not think there is a problem, but know there is a perception of a problem:**
  - Explain the true situation, and
  - Provide supporting documentation.

## Exam Communications

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- Examiners issue two general types of referral communications during their review of company procedures and files:
  - Request for Information (“RFI”)
  - Criticism (“Crit”)
- Coordinator Triage System:
  - Keep spreadsheet of all documents (in and out).
  - May be needed for later litigation.
  - Be sure to document any attorney involvement that could render list privileged.

## During the Exam – Basic Actions

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- **Don't automatically defend** company's every action in a criticism response.
  - If there was a mistake, admit it, but focus on correction.
- **Address problems early**, or they grow.
- **Stay ahead of the examiners.**
  - Always be formulating strategy for the next step of the exam process, while the examiners are still on the prior step.

## Responding to Examiners' Requests

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- Promptly: If the examiner sets a deadline, either meet the deadline or request an extension well in advance of the deadline. **Keep a log of all questions and answers.**
- Completely but Briefly: Ask follow up questions before the response is due, if the question is not clear. **Stick to answering only the question posed.**
- Clearly: Remember, examiners may not be familiar with company terms and acronyms. Be sure they are easy to understand on the first reading.
- Accurately: Take the time to vet responses carefully to verify that they contain correct facts, company stance.

## During the Exam – Big Picture View

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- Be on the look-out for trends or “policy” issues.
  - Consider a detailed, global response to avoid repetition, resolve sufficiently.
  - Should company voluntarily develop a remediation plan to present to the examiners?
  - Is there a fundamental disagreement that needs to be evaluated within the examining state’s department?
- Correct misunderstandings examiner may have regarding company policy/practices

## Common Mistakes

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- Not controlling the timing of the exam.
  - Constant pressure on examiners to meet time commitments
  - Insurer must meet own deadlines to keep exam moving
  - In conjunction with press articles or pending litigation
- Not seeking timely instruction from company management regarding position on issues and resolutions.
- Not managing company executive's expectations.
- Being too inflexible.

# Keep Up Morale, Even When the Examiners Tire You Out...

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## During the Exam – Potential Problems with Examiner

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- Disagreement on legal issue or other issue that is decided as a matter of policy.
  - Consider Department management's intervention.
- Issues with an examiner's conduct or bias.
  - Consider asking Chief Examiner or other examiners for help or going to examiner's supervisor.
- Examiners who won't leave.
  - Consider documenting pace of review, number of referrals generated, number of files reviewed.
  - Seek advice or assistance of Chief Examiner.
- Lack of coordination among examiners (on referrals, issue resolution).
  - Consider an interim meeting.
  - Pressure Chief Examiner – discreetly.
- Lack of responsiveness of examiners.
  - Be patient, apply pressure, give bite-sized requests

## During the Exam – Potential Problems Unrelated to Examiner

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- AG Investigations
  - Less often an issue in CA than other states
- Bad Media Press
  - Have a message prepared if this is a possibility
- Examination by other states or MAWG on similar issues
  - Coordination within company is key – especially when states are not themselves coordinating

## During the Exam – Litigation

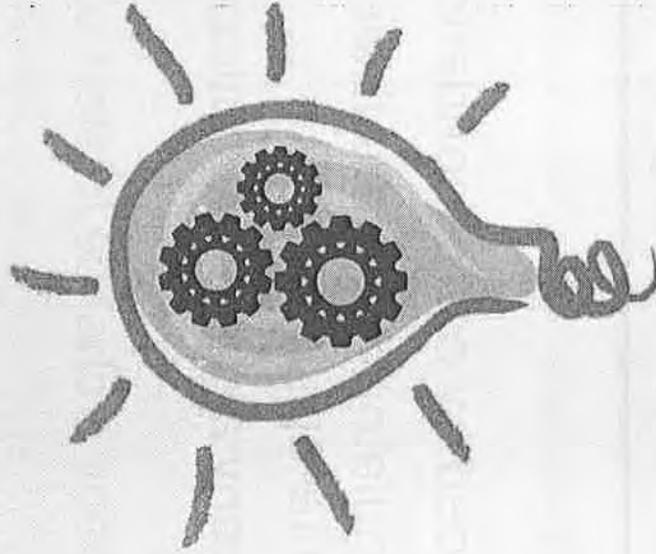
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- Impact of exam on civil litigation (discovery requests, collateral estoppel issues).
  - Consider primary jurisdiction arguments, seeking stay, or asserting confidentiality of exam working papers.
  - Coordinate with civil litigation team early and often.
  - Verify exam and civil litigation strategies are complementary.
- Possibility that plaintiff's bar is aware of exam or exam issues

# Chapter Four

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## RESOLVING EXAMINATION ISSUES



## The Exam Report – Preliminary Draft

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- May be preceded by correspondence in letter form
- Encourage regulators to share their drafts and preliminary write-ups.
  - Gives company a chance to anticipate problems in report.
  - Gives company a chance to start communicating its message.
  - Gives company a chance to influence form and content of final report.
  - Gives company a chance to correct any factual inaccuracies.

## The Exam Report – Company Input

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- Be prepared to flyspeck for misstatements of law or fact.
  - Don't just give in on inaccuracies.
- Ask for soft copies (e.g., Word files) of draft reports, so company can return suggested revisions in track changes format.
- Determine whether all examiners agree with content of report. (They may not!)
- Be prepared to dispute findings!

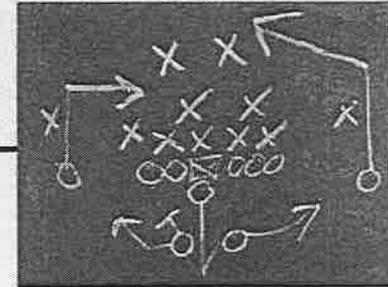
## The Exam Report(s)

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- Reports may be made public.
  - Violations of 790.03 and interpreting regulations segregated in report that is posted on CDI website
  - In 2008, the CA DOI posted 45 Market Conduct Examination Reports on its web site.
- Company's Response is incorporated into the report
  - Summary form
  - Only with respect to individual criticisms
  - Letter response after final report issued
- The final report is **IMPORTANT** as it will be raised in future DOI interactions and may be used in future or pending lawsuits and other states' market analysis.

# Resolution Planning

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Establish company objectives and game plan:

- Goal to Minimize:
  - Damage to company's reputation.
  - Financial harm to company.
  - Stockholder uncertainty.
  - Cost in time, training, and procedural change due to issue resolution – national v. local changes.
  - Other exposures - other states, civil litigation, etc.
- What changes can be made to resolve criticisms?

## DOI Options for Enforcement Activity

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- Close Exam With No Further Action
- Settlement Negotiations
- Formal Enforcement Action Notice
- Administrative Litigation (Formal Hearing)
- Participation in Multi-agency or Multi-state Action

## Publicity Surrounding Enforcement Actions

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- California issues an enforcement pleading and also a formal order before it settles an exam.
  - Public documents
  - Level of detail varies
- Legal documents related to enforcement action are also public.
- Insurance commissioners like press releases.

## Enforcement Actions

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- Generally conducted by a different cast of characters than the examiners.
  - DOI lawyers and management
  - Administrative Law Hearing
- **More** focused on **legal** issues.
- **Less** focused on **factual** issues.



## Settlement – Most Likely Option

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- Experience shows settlement much more likely than formal hearing.
- Timeframe from exam report to settlement varies widely.
- Terms of Resolution
  - Usually involve remediation
  - May or may not also involve fine
  - May or may not involve reimbursement of CDI prosecution costs



## Settlement Strategy

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- Demonstrate a compliance attitude.
  - Actively identify and address compliance issues.
  - Renew focus on servicing claims/policies properly and expeditiously.
  - Awareness of senior and disability issues and active approach to addressing such.
  - Action to right any wrongs.
  - Show that company stands behind its very useful and needed products.
- Think creatively

## Tools to Use with Regulators

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- Refer to NAIC Market Regulation Handbook Standards, Tolerances, and Best Practices (or Model Laws).
  - DOI should be taking least intrusive action on Continuum of Regulatory Responses.
- Note push for uniformity among states to avoid federal regulation – what have other states accepted?
- Cite prior DOI approvals or acceptances of the criticized activity (rate and form filing, prior exam findings, etc.).
- Seek statement of legal authority for the proposed criticism or recommended correction.
- Establish timelines at the outset and seek DOI compliance with initial agreements.

## Tools Regulators Use Against Insurers

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- Maximize findings with easy criticisms:
  - Timelines, notice language, disclosures, bad data.
- Exploit gabby responses – company says too much:
  - Do not admit fault, speculate, identify bigger issues.
- Take Advantage of company's desire to please examiners:
  - Examiner cannot guarantee no further action.
  - Examiner might overstate authority.
  - Examiner judged by number of criticisms cited.
- Threats of further action:
  - Such as subpoena, fine, extended duration, broader scope.

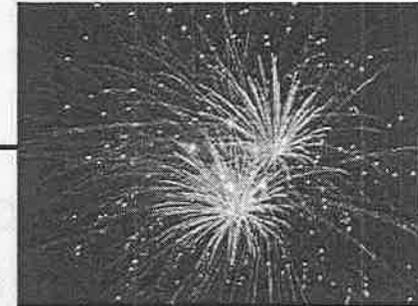
## 6 Things to Seek in Every Exam Action Settlement

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- Moratorium on new exams for a period of time
- Release
- No admission of fact or veracity of the allegations
- Clear scope
- Moratorium and release cover full scope of issues examined...not just where problems found
- Understanding regarding the sharing of press releases and basic questions and answers for media interviews and communications

# Upon Final Resolution

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- Celebrate the benefits of resolution.
- Prepare for the **repercussions** of resolution:
  - Outlier state attention.
  - Consumer dissatisfaction with settlement.
  - Legislative response to problems at issue.
  - Stockholder response to resolution.
- Ensure corrective actions and reporting requirements are fully performed – **repeat criticisms are treated harshly by DOIs.**

## Chapter Five

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- RECENT LESSONS LEARNED
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# Questions and Answers

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