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11 **BEFORE THE INSURANCE COMMISSIONER**  
12 **OF THE STATE OF CALIFORNIA**

13  
14 In the Matter of  
15 PACIFICARE LIFE AND HEALTH  
16 INSURANCE COMPANY,  
17 Respondent.

File No. UPA 2007-0004

OAH No. 2009061395

**OFFER OF PROOF RE RELEVANCE OF  
DMHC'S \$2 MILLION PENALTY  
ASSESSED AGAINST PACIFICARE**

Judge: Hon. Ruth S. Astle

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- 3 Ex. 165 March 27, 2007 letter from CMA to CDI
- 4 Ex. A March 13, 2007 letter from CMA to DMHC
- 5 Ex. 5040 May 17, 2007 joint letter from CDI and DMHC to the CMA
- 6 Ex. 5174 June 5, 2007 email from C. Vandepas to J. Dougherty
- 7 Ex. 5175 June 22, 2007 email J. Noziak to C. Dixon
- 8 Ex. 5178 July 17, 2007 informal CDI meeting with DMHC examiners
- 9 Ex. B July 20, 2007 email from C. Vandepas to A. Dougherty (CDI00001645)
- 10 Ex. 5176 July 20, 2007 email from J. Nozaki to C. Dixon
- 11 Ex. C July 16, 2007 DMHC Preliminary Interim Report
- 12 Ex. 5060 August 18, 2007 email from D. Towanda to E. Johnsen
- 13 Ex. 5061 CDI chart re corresponding Insurance Code provision for each violation cited
- 14 by DMHC
- 15 Ex. 5272 January 29, 2008 CDI and DMHC joint press release
- 16 Ex. D Jan. 16, 2008 DMHC Final Report
- 17 Ex. 5263 DMHC's written confirmation that 28 CCR § 130071 does not require written
- 18 acknowledgement letters
- 19 Ex. E February 26, 2008 letter from DMHC to Nancy Monk
- 20
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1       **I. Introduction**

2           The nearly one million alleged violations and unprecedented penalties asserted by the  
3 California Department of Insurance (“CDI”) in this enforcement proceeding originated in a  
4 simultaneous, joint investigation of PacifiCare Life & Health Insurance Company (“PLHIC”)  
5 and PacifiCare of California (“PCC/HMO”) by, respectively, CDI and the Department of  
6 Managed Health Care (“DMHC”). This brief presents an offer of proof that DMHC’s \$2 million  
7 administrative penalty assessed in its parallel proceeding (Enforcement Matter No. 07-356) is  
8 relevant to show that the staggering penalties that CDI seeks in this proceeding are excessive  
9 and unconstitutional.

10           Under settled California and federal law, the state and federal Due Process Clauses and  
11 the Excessive Fines Clause of the Eighth Amendment require that a civil penalty be reasonably  
12 related to penalties imposed under similar statutes for comparable conduct. DMHC’s \$2 million  
13 administrative penalty was assessed for alleged conduct substantially similar in nature and scope  
14 to that at issue here. Both regulators apply similar statutory penalty schemes. Accordingly,  
15 evidence regarding DMHC’s \$2 million administrative penalty is relevant to this case and  
16 admissible.

17       **II. Factual Background**

18           **A. This Proceeding Originated In CDI’s And DMHC’s Joint Investigation**  
19           **Of The PacifiCare Companies**

20           The evidence shows that this proceeding originated in CDI’s and DMHC’s joint  
21 investigation. For example, both regulators’ 2007 examinations were prompted by letters and  
22 communications from the California Medical Association (“CMA”). (Ex. 165 (March 27, 2007  
23 letter from CMA to CDI); Ex. A (March 13, 2007 letter from CMA to DMHC.) After CDI and  
24 DMHC had informed the PacifiCare companies that these regulators would be undertaking their  
25 respective examinations, CDI and DMHC wrote a joint letter on May 17, 2007 to the CMA,  
26 which was signed by CDI’s Deputy Commissioner and DMHC’s Deputy Director. They  
27 advised that the two regulators would be “working jointly and coordinating [their] investigative  
28 efforts to the maximum extent possible.” (See Ex. 5040.) Indeed, CDI’s counsel has

1 acknowledged the two agencies' joint investigation on the record:

2 ... to give a little background, this was a joint investigation. The  
3 Department embarked on a joint, the Department of Insurance  
4 embarked on a joint investigation with the DMHC. And as part of that  
5 joint investigation, we agreed that we would exchange certain  
6 documents. (12/1/09 Hg., p. 71.)

7 The two regulators in fact did work jointly and coordinated their efforts in the summer of  
8 2007. For example, CDI examiners subsequently attended DMHC's examination entrance  
9 conference with PCC/HMO on June 4 and 5 to garner information for use in CDI's examination  
10 of PLHIC, which had not yet begun. (Ex. 5174.) CDI's lead examiner, Coleen Vandepas,  
11 expressed her appreciation to DMHC for including CDI in the entrance conference. She stated  
12 that the information obtained during the meeting would be of "great use in [her] review and  
13 analysis" of PLHIC's PPO business. (Ex. 5174.) CDI and DMHC later entered into "a written  
14 confidentiality agreement ... to share information" regarding DMHC's examination of  
15 PCC/HMO. (Ex. 5175.) CDI and DMHC examiners met on July 17 to discuss DMHC's  
16 findings and "experiences at PHLIC/UHIC." (Ex. 5178.) On July 20, DMHC provided CDI  
17 with DMHC's document requests used during its examination of PCC/HMO for incorporation  
18 into CDI's investigation of PLHIC (Ex. B (CDI00001645; July 20, 2007 email from C.  
19 Vandepas to A. Dougherty), as well as DMHC's Interim Preliminary Report, which set forth  
20 DMHC's findings for conduct that allegedly occurred during the same period that was the focus  
21 of CDI examination. (Ex. 5176; Ex. C (July 16, 2007 DMHC Interim Report).) On August 18,  
22 2007, CDI revised its contemplated investigation plan to focus on the same issues identified by  
23 DMHC in its Interim Report. (See Ex. 5060.) CDI instructed its examiners to "re-work the  
24 Comparison Codes Checklist to include all DMHC issues identified in [DMHC's] Interim Draft  
25 Report." (*Id.* (emphasis in original).) CDI also instructed its examiners to identify the  
26 corresponding Insurance Code provision for each violation cited by DMHC and informed them  
27 that "[m]anagement expects that in our sample file review, we will see the same issues as  
28 DMHC identified in their report with respect to PLHIC claims handling." (See *id.*; see also Ex.  
5061.)

After concluding their examinations, CDI and DMHC issued a joint press release on

1 January 29, 2008 touting their “collaborative effort” as the “first action ever by both CDI and  
2 DMHC against a single health plan or insurer” and “announc[ing] a joint action against  
3 PacifiCare companies.” (Ex. 5272.) According to the January 29, 2008 press release, the “joint  
4 investigation” yielded findings of “alleged violations cited by CDI and DMHC” including the  
5 following:

- 6 • [alleged] wrongful denials of covered claims;
- 7 • [alleged] incorrect payment of claims;
- 8 • [alleged] lost documents including certificates of  
9 creditable coverage and medical records;
- 10 • [alleged] failure to timely acknowledge receipt of  
11 claims;
- 12 • [alleged] multiple requests for documentation that  
13 was previously provided;
- 14 • [alleged] failure to address all issues and respond  
15 timely to member appeals and provider disputes;  
16 [and]
- 17 • [alleged] failure to manage provider network  
18 contracts and resolve provider disputes. [*Id.*]

19 Based on its “collaborative effort” and “joint action,” DMHC assessed an administrative  
20 penalty of \$2 million. [Ex. D (DMHC Final Report dated Jan. 26, 2008); Ex. E (Letter, p.2).]

21 **B. DMHC’S \$2 Million Penalty Was Assessed For Substantially Similar  
22 Alleged Conduct Under A Substantially Similar Penalty Scheme.**

23 For violations of Health and Safety Code Sections 1340 through 1399.818 (the Health  
24 Care Services Plan Chapter 2.2) and related regulations, the DMHC Director may impose  
25 administrative penalties after notice and an opportunity for hearing (Health & Safety Code §  
26 1386) or, alternatively, seek civil penalties up to \$2,500 per violation in a civil action (*id.* §  
27 1387) or criminal penalties up to \$10,000 per willful violation (*id.* § 1390) in a criminal  
28 proceeding. In a civil penalty action, the DMHC Director also may seek a \$2,500 civil penalty

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24 <sup>1</sup> This quotation from the January 29, 2008 press release is inaccurate in at least one respect. It states  
25 that DMHC and CDI both cited the PacifiCare companies for violations based on an alleged failure to  
26 acknowledge claims. In fact, DMHC did *not* allege any such violations in its examination reports. (*See*  
27 Ex. C [July 16, 2007 DMHC Preliminary Report]); Ex. D (Jan. 26, 2008 DMHC Final Report).) To the  
28 contrary, DMHC confirmed, in writing, that its claims handling regulation, 28 CCR § 130071 -- after  
which Insurance Code section 10133.66(c)2 is modeled -- does not require written acknowledgement  
letters. (Ex. 5263.)

1 for each day of a continuing violation, or for each consumer injured by a particular violation.  
2 See 28 C.C.R. §1300.87.

3 Here, CDI seeks to impose penalties under Insurance Code Section 790.035, a statute  
4 authorizing comparable penalties to those available to the DMHC. Insurance Code Section  
5 790.035 authorizes a civil penalty “not to exceed five thousand dollars (\$5,000) for each act, or,  
6 if the act was willful, a civil penalty not to exceed ten thousand dollars (\$10,000) for each act.”  
7 Ins. Code § 790.035(a).

8 In connection with its parallel Enforcement Matter No. 07-356, DMHC elected to assess  
9 an administrative penalty against PCC/HMO pursuant to Section 1386, rather than pursue civil  
10 and/or criminal penalties. The DMHC regulations provide that the following factors are  
11 pertinent to determining an appropriate administrative penalty:

12 (a) When assessing administrative penalties against a health  
13 plan the Director shall determine the appropriate amount of the penalty  
14 for each violation of the Act based upon one or more of the factors set  
15 forth in subsection (b).

16 (b) The factors referred to in subsection (a) include, but are not  
17 limited to the following:

- 18 (1) The nature, scope, and gravity of the violation;
- 19 (2) The good or bad faith of the plan;
- 20 (3) The plan’s history of violations;
- 21 (4) The willfulness of the violation;
- 22 (5) The nature and extent to which the plan cooperated with the  
23 Department's investigation;
- 24 (6) The nature and extent to which the plan aggravated or  
25 mitigated any injury or damage caused by the violation;
- 26 (7) The nature and extent to which the plan has taken corrective  
27 action to ensure the violation will not recur;
- 28 (8) The financial status of the plan;
- (9) The financial cost of the health care service that was denied,  
delayed, or modified;
- (10) Whether the violation is an isolated incident; and/or
- (11) The amount of the penalty necessary to deter similar  
violations in the future. [28 C.C.R. § 1300.86.]

The DMHC factors considers in assessing penalties are similar to the above factors:

(a) In determining whether to assess penalties and if so the  
appropriate amount to be assessed, the Commissioner shall consider  
admissible evidence on the following:

- (1) the existence of extraordinary circumstances;

1 (2) whether the licensee has a good faith and reasonable basis to  
2 believe that the claim or claims are fraudulent or otherwise in violation  
of applicable law and the licensee has complied with the provisions of  
Section 1872.4 of the California Insurance Code;

3 (3) the complexity of the claims involved;

4 (4) gross exaggeration of the value of the property or severity of  
the injury, or amount of damages incurred;

5 (5) substantial mischaracterization of the circumstances  
surrounding the loss or the alleged default of the principal;

6 (6) secreting of property which has been claimed as lost or  
destroyed.

7 (7) the relative number of claims where the noncomplying act(s)  
are found to exist, the total number of claims handled by the licensee  
and the total number of claims reviewed by the Department during the  
relevant time period;

8 (8) whether the licensee has taken remedial measures with  
respect to the noncomplying act(s);

9 (9) the existence or nonexistence of previous violations by the  
licensee;

10 (10) the degree of harm occasioned by the noncompliance;

11 (11) whether, under the totality of circumstances, the licensee  
made a good faith attempt to comply with the provisions of this  
subchapter;

12 (12) the frequency of occurrence and/or severity of the  
detriment to the public caused by the violation of a particular  
subsection of this subchapter;

13 (13) whether the licensee's management was aware of facts that  
apprised or should have apprised the licensee of the act(s) and the  
licensee failed to take any remedial measures; and

14 (14) the licensee's reasonable mistakes or opinions as to  
valuation of property, losses or damages.

15 (b) This section shall not bar, obstruct or restrict any right to  
16 administrative due process an insurer may be afforded under California  
17 Insurance Code Sections 790.05, 790.06, and 790.07.

18  
19 In assessing its \$2 million administrative penalty, DMHC cited its findings and  
20 violations based on alleged deficiencies in PCC/HMO's claim handling practices and provider  
21 dispute resolution handling practices, as well as its administrative capacity to manage both  
22 systems, which are comparable to the conduct alleged by CDI in this proceeding. (Ex. D  
23 (DMHC Final Report dated Jan. 26, 2008).) PCC/HMO did not contest DMHC's findings or the  
24 \$2 million penalty assessment. (Ex. E (DMHC Letter, p.2).)

25 **III. DMHC's \$2 Million Penalty Assessed Against PLHIC Is Relevant To PLHIC's**  
26 **Due Process Attack On The Penalties CDI Seeks In This Proceeding**

27 Constitutional limitations are properly raised in this administrative proceeding. As one  
28 treatise explains, "[p]arties may challenge any aspect of a hearing as procedurally inadequate

1 under applicable *constitutional* and statutory provisions, and counsel should be alert to possible  
2 procedural violations throughout the administrative proceeding.” J.R. Roman, *Cal. Admin.*  
3 *Hearing Practice*, Ch. 7, “The Hearing Process,” § 7:14, pp. 356-357 (CEB 2d ed.) (incl. 2009  
4 update). Indeed, that treatise indicates that these constitutional challenges must be raised “at the  
5 administrative level to preserve the question for review.” *Id.*, p. 356.

6 Due process and the Excessive Fines Clause of the Eighth Amendment require that any  
7 civil penalty that may be assessed against PLHIC be reasonably related to penalties imposed  
8 under similar statutes for comparable conduct. *See People v. R.J. Reynolds Tobacco Co.*, 37  
9 Cal. 4th 707, 728 (2006) (courts assessing a penalty should consider: “(1) the defendant's  
10 culpability; (2) the relationship between the harm and the penalty; (3) the penalties imposed in  
11 similar statutes; and (4) the defendant's ability to pay.”) (emphasis added); *United States v.*  
12 *Bajakajian*, 524 U.S. 321, 337-338 (1998) (excessiveness of civil penalty evaluated by  
13 examining other penalties for like offenses and noted that “other penalties that the Legislature  
14 has authorized are certainly relevant evidence”); *Hale v. Morgan*, 22 Cal. 3d 388, 400 (1978)  
15 (penalty imposed against landlord for terminating utilities violated due process because it was  
16 “inconsistent with the statutory norm”).<sup>2</sup>

17 Review of penalties available under similar statutes is a key factor in deciding whether  
18 an administrative civil penalty “clearly exceed[ed] any appropriate and proportionate sanction  
19 for wrongful termination” of utilities. *Id.* at 403-04. The *Hale* case is illustrative. In *Hale*, a  
20 mobile home park tenant filed suit against his landlord under a civil statute, Civ. Code Section  
21 789.3, which imposed a civil penalty of \$100 a day against any landlord who willfully  
22 terminates a tenant’s utility services. 22 Cal. 3d at 393. At the time the tenant moved out of the  
23 mobile home park, services had been disconnected for 173 days, and the trial court imposed a  
24 penalty of \$17,300. *Id.* at 394. In deciding whether the fine violated due process, the Supreme  
25 Court examined penalties available under other California laws pertaining to the landlord-tenant

26 \_\_\_\_\_  
27 <sup>2</sup> In the civil penalty context, “it makes no difference whether [courts] examine the issue as an excessive  
28 fine or a violation of due process.” *R.J. Reynolds*, 37 Cal. App. 4th at 728.

1 relationship – Civil Code Section 1942 concerning eviction, Code of Civil Procedure Section  
2 1942.5 prohibiting forcible entry by a landlord and Civil Code Section 1941 requiring the  
3 landlord to maintain the premises in habitable condition – and found that the penalties in those  
4 statutes did not permit fines as “severe” as the one imposed by the trial court. *Id.* at 400 (“[W]e  
5 find it noteworthy that the sanction imposed by section 789.3 is potentially more severe than that  
6 provided by the Legislature for other more serious transgressions by the landlord against the  
7 tenant”).

8 The Court in *Hale* also conducted a “review of other civil penalties provided by  
9 California law” outside the landlord-tenant context, such as penalties under the Public Utility  
10 Code and under the Health and Safety Code, to compare the “monetary assessments for other  
11 forms of civil misconduct,” and concluded that those penalties “emphasize[] the harsh impact,  
12 approaching confiscation” of the challenged penalty under Section 789.3 that was levied by the  
13 trial court. *Id.* at 401. Finally, the Court considered other states’ statutory penalty schemes for  
14 conduct similar to that punished by Section 789.3: “[A]t least 14 other jurisdictions have enacted  
15 legislation which, in some form, prohibits the interruption of utility service by a landlord ...  
16 [but] no other jurisdiction appears to impose a penalty so severe[.]” *Id.* at 403. The Court  
17 concluded the penalty before it was “inconsistent with the statutory norm” and reversed the  
18 judgment against the landlord. *Id.* at 400, 405.

19 In the punitive damages context, the United States Supreme Court also has analyzed  
20 “civil penalties authorized or imposed in comparable cases” in deciding whether a punitive  
21 damage award violated due process. *See State Farm Mutual Automobile Ins. Co. v. Campbell*,  
22 538 U.S. 408, 417 (2003). Similar to the four-factor analysis adopted by the California Supreme  
23 Court in *R.J. Reynolds Tobacco Co.*, the United States Supreme Court utilized a three-factor  
24 analysis: “(1) the degree of reprehensibility of the defendant's misconduct, (2) the disparity  
25 between the actual or potential harm suffered by the plaintiff and the punitive damages award,  
26 and (3) the difference between the punitive damages awarded by the jury and the civil penalties

1 authorized or imposed in comparable cases.” *Campbell*, 538 U.S. at 409 (emphasis added)  
2 (citing *BMW of North America, Inc. v. Gore*, 517 U.S. 559, 575 (1996)).<sup>3</sup>

3 In *Campbell*, insureds in Utah brought claims for bad faith, fraud and intentional  
4 infliction of emotional distress against their automobile liability insurer (State Farm) after it  
5 rejected settlement offers within policy limits and ignored the advice of its own investigators in  
6 taking an underlying automobile injury accident against its insureds to trial. *Id.* at 413. The  
7 underlying action resulted in a verdict in excess of policy limits, and the subsequent bad faith  
8 action against State Farm resulted in a compensatory award of \$1 million and a punitive award  
9 of \$145 million. *Id.* at 415. The \$145 million award was based on evidence of State Farm’s  
10 fraudulent nationwide operations designed to limit claim payments. *Id.* In deciding that the  
11 punitive damages award violated due process and was an excessive fine, the United States  
12 Supreme Court examined comparable civil penalties under Utah law for similar conduct. *Id.* at  
13 428. The Court noted that “we need not dwell long on” this factor, as “the most relevant civil  
14 sanction under Utah state law for the wrong done to [the insureds] appears to be a \$10,000 fine  
15 for an act of fraud, an amount dwarfed by the \$145 million punitive damages award.” *Id.*

16 Here, DMHC’s \$2 million administrative penalty was assessed for alleged conduct  
17 substantially similar in nature and scope to that alleged by CDI in this proceeding. Both  
18 regulators apply similar statutory penalty schemes. Yet DMHC’s \$2 million penalty dwarfs in  
19 comparison to the staggering penalties sought by CDI. In light of the foregoing authorities,  
20 DMHC’s \$2 million penalty thus is relevant proof that the penalties sought by CDI are excessive  
21 and unconstitutional.

22 Despite these controlling authorities, CDI nevertheless may argue that the statute under

23  
24 <sup>3</sup> In *People ex rel. Bill Lockyer v. Fremont Life Ins. Co.*, 104 Cal. App. 4th 508, 521 (2002), the Court of  
25 Appeals addressed the argument that a civil penalty violated federal due process because it was grossly  
26 excessive in relation to the state’s interest in protecting its consumers. The Court of Appeals noted that  
27 *BMW v. Gore* “refers to civil penalties for purposes of comparison with punitive damage awards to  
28 evaluate whether the awards were excessive [but] *BMW v. Gore* does not apply the guidelines to civil  
penalties.” *Id.* This decision, however, was issued before the California Supreme Court in *R.J. Reynolds*  
confirmed that the *Gore* factors do apply to evaluating whether civil penalties violate due process. *See*  
*R.J. Reynolds*, 37 Cal. 4th at 728.

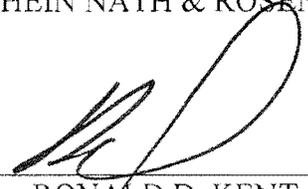
1 which DMHC assessed its \$2 million penalty – Health and Safety Code Section 1386(a) – is  
2 distinguishable, because it does not set a penalty amount for each “violation” committed by the  
3 plan. That argument misses the point. DMHC’s statutory and regulatory penalty scheme also  
4 includes Health and Safety Code Section 1387, under which DMHC may seek civil penalties up  
5 to a maximum of \$2,500 for each violation, in addition to seeking other penalties against a plan,  
6 and Regulation 1300.87, which further provides that a \$2,500 penalty under Section 1387 may  
7 be assessed for each day of a continuing violation, or for each consumer injured by a particular  
8 violation. See 28 CCR §1300.87. With respect to criminal penalties, Health and Safety Code  
9 Section 1390 allows for the imposition of criminal penalties not in excess of \$10,000 per willful  
10 violation. *Id.* Thus, there is no meaningful distinction.

11 **IV. Conclusion**

12 As shown above, evidence regarding DMHC’s \$2 million administrative penalty should  
13 be admitted. It is relevant to an important issue in this case, namely whether the excessive  
14 penalties that CDI seeks in this proceeding violate due process (which they plainly do). PLHIC  
15 has the right to, and indeed must, contest the issue in this administrative action. Thus, it would  
16 be prejudicial error to exclude this evidence.

17 Dated: July 13, 2010

SONNENSCHN NATH & ROSENTHAL LLP

18  
19  
20 By   
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**PROOF OF SERVICE**

I, Ronald D. Kent, hereby declare: I am employed in the City and County of San Francisco, California in the office of a member of the bar of this court at whose direction the following service was made. I am over the age of eighteen years and not a party to the within action. My business address is Sonnenschein Nath & Rosenthal LLP, 525 Market Street, 26th Floor, San Francisco, California 94105. On July 13, 2010, I served:

**OFFER OF PROOF RE RELEVANCE OF DMHC'S \$2 MILLION PENALTY ASSESSED AGAINST PACIFICARE**

on the interested parties in this action by placing a true copy thereof, on the above date, enclosed in a sealed envelope, addressed as follows:

Michael J. Strumwasser Bryce Gee Strumwasser & Woocher LLP 10940 Wilshire Boulevard Suite 2000 Los Angeles, CA 90024 mstrumwasser@strumwooch.com bgee@strumwooch.com loliver@strumwooch.com	Andrea Rosen California Department of Insurance Legal Division Health Enforcement Bureau 300 Capitol Mall, 17th Floor Sacramento, CA 95814 rosen@insurance.ca.gov
---	--

**(By Mail):** I am personally and readily familiar with the business practice of Sonnenschein Nath & Rosenthal LLP for collection and processing of correspondence for mailing with the United States Postal Service, pursuant to which mail placed for collection at designated stations in the ordinary course of business is deposited the same day, proper postage prepaid, with the United States Postal Service.

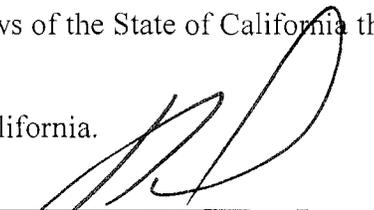
**(By Hand):** I caused a true copy of the foregoing document to be served by hand delivery.

**(By Federal Express):** As follows: I am "readily familiar" with the firm's practice of collection and processing correspondence for Federal Express delivery. Under that practice, it would be picked up by a Federal Express representative on that same business day at San Francisco, California, in the ordinary course of business.

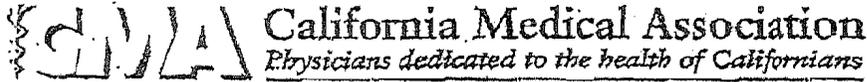
**(By Electronic Mail):** I transmitted the above documents by electronic mail to the interested parties via the e-mail addresses listed above for each party.

I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

EXECUTED on July 13, 2010, at Oakland, California.

  
\_\_\_\_\_  
Ronald D. Kent





March 27, 2007

David Link  
Deputy Commissioner, Legislative Director  
Department of Insurance  
300 Capitol Mall, Suite 1700  
Sacramento, CA 95814

Re: Formal Request for an Investigation Regarding UnitedHealthcare/PacificCare's Claims Practices

Dear Deputy Commissioner Link:

On behalf of the California Medical Association (CMA), we are respectfully requesting that you conduct a formal investigation of UnitedHealthcare practices with respect to the payment of claims of their covered insureds. A detailed description of these problems, along with supporting evidence, has already been provided to the Department in a letter dated February 16, 2007, to Andrea J. Rosen, MPH, JD. We have attached a copy of that letter for your review. The individual issues included in our February 17<sup>th</sup> letter have largely been resolved through an informal liaison process UnitedHealthcare has agreed to participate in with CMA. However, it does not appear that UnitedHealthcare has made a commitment to eliminating these problems on a systemic level, as CMA continues to receive similar complaints from other physicians on a daily basis.

As you can see, since the PacificCare/UnitedHealthcare merger, it has engaged in widespread misconduct, including:

- Not entering into its computer systems contract rates that have been negotiated between physicians and the insurer in a timely manner;
- Loading contract rates into its system incorrectly;
- Failing to process contract terminations in a timely manner;
- Incorrectly identifying physicians' participation status of its roster to insureds;
- Not responding to physicians' payment disputes; and

David Link  
Deputy Commissioner, Legislative Director  
Formal Request for an Investigation Regarding UnitedHealthcare/PacificCare's Claims Practices  
March 27, 2007  
Page 3

representative) may file a written complaint with the Department with respect to the handling of a health insurance claim or with respect to any alleged misconduct. The Commissioner then must notify the complainant of the receipt within ten (10) business days and issue a written determination within sixty (60) calendar days of the date of its receipt, unless additional time is reasonably necessary to fully and fairly evaluate the complaint. With respect to contracts with physicians and other providers, the Legislature mandated that the Department of Insurance annually compile all provider complaints that it receives and report to the Legislature and the Governor the number and nature of those complaints, by March 15 of each calendar year. See Insurance Code §10166.65.

Given the new leadership at the DOI, as well as the increasing market share exercised by DOI's regulated health care insurers, we believe it is particularly critical that the Department of Insurance make complaints raised by all providers, including their representatives such as CMA, seriously and enforce the law as appropriate.

The following discussion details each of the problematic activities and potential laws to redress them.

#### **Not Entering into Its Computer Systems Contract Rates That Have Been Negotiated Between Physicians and the Insurer in a Timely Manner**

Where a health insurer fails to enter into its system the rate it negotiated with a health care provider in a timely manner, it treats that health care provider as one that is "out of network" and therefore pays the claims at an incorrect rate. As a result, the patient's share of cost is increased (since the patient would not be benefited by the discounted rate negotiated by the health care provider) and a physician's administrative costs are increased in adjudicating the claim (since physicians either need to hold the claim until the correct contract rate has in fact been entered into the system, or engage in untold hours in adjudicating each claim on a case-by-case basis, with both the insurer and patient.) Provisions that could be used to redress this unlawful activity include the following:

- a. Insurance Code §§10123.13 and 10123.147. These provisions require insurers to pay the proper covered amount (based upon either the contract or its out of network benefit) upon receipt of a complete claim no later than 30 working days after receipt of the claim unless the claim is contested or denied. To the extent the claim is not paid properly pursuant to these provisions, the insurer must also pay an additional interest penalty.
- b. Insurance Code §10291.5. This section is intended to prohibit unsound disability insurance from the marketplace. If insureds are paying higher out of network rates for physicians who have negotiated lower rates but whose contracts have not been loaded into the system, then there is no "real economic value" of the policy to the insured.

David Link  
Deputy Commissioner, Legislative Director  
Formal Request for an Investigation Regarding UnitedHealthcare/PacificCare's Claims Practices  
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- b. Insurance Code §10133.65. This provision prohibits, among other things, contracts that allow for the unilateral amendment of fee schedules. Subdivision (c) allows material changes only if the health insurer provides at least forty-five (45) business days notice to the provider, and the provider has the right to terminate the contract prior to the implementation of the change. Where a contract rate is loaded incorrectly, that in fact amounts to an amendment to the contract, which is unlawful.
- c. Insurance Code §§779.19 and 790.03, and 10 C.C.R. §2695.3(a). Again, these provisions require that insurers maintain adequate systems in place to ensure that claims are paid properly and fairly. See discussion above, a failure to load contracted rates accurately necessarily means that such adequate systems are not in place.

#### Incorrectly Identifying Physicians' Participation Status of Its Roster to Insureds

CMA's February 16, 2007 letter also detailed a number of circumstances where physicians who had in fact signed contracts with UnitedHealthcare were not included on the participating roster, or physicians who had terminated their contracts with UnitedHealthcare were listed as participating on the UHC website. In either case, this activity is flatly misleading and violates a number of Insurance Code provisions including:

- a. Insurance Code §10133.1. This provision requires that insurers provide group policy holders with a current roster of institutional and professional providers under contract to provide services at alternative rates under their group policy. For this provision to be meaningful, this roster must be accurate and complete, otherwise this provision which promotes patient choice and continuity of care would be defeated.
- b. Insurance Code §780. This provision prohibits, among other things, insurers from causing or permitting misrepresentations concerning the benefits or privileges promised under an insurance policy. To the extent a roster contains names of physicians who are in fact non-participating, a prohibited misrepresentation has occurred.
- c. Insurance Code §790.03. This provision declares as an unfair method of competition an unfair and deceptive act or practice in the business of insurance "making, issuing, circulating," or causing to be made, any statement misrepresenting the terms of any policy, or the benefits or advantages promised under such a policy. Again, to the extent a roster contains names of physicians who are in fact non-participating, a prohibited misrepresentation has occurred.

David Link  
Deputy Commissioner, Legislative Director  
Formal Request for an Investigation Regarding UnitedHealthcare/PacificCare's Claims Practices  
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- b. Insurance Code §10123.137. This provision requires that health insurers contain a fair, fast, and cost effective dispute resolution mechanism, and to resolve each provider dispute, consistent with applicable law, and issue a written determination within forty-five (45) business days after the date of the receipt of the provider dispute. It appears there has been no effort to comply with this provision.

#### Failing to Disclose Insured Status of Claim

To further exacerbate all these problems, UnitedHealthcare fails to clearly disclose on either the health insurance card or the EOB or remittance advice whether the beneficiary is covered by an insured or self-insured product. United Healthcare further takes the unsupportable position that ERISA preempts all California laws applicable to it when it is functioning as a TPA. Then if a physician attempts to challenge any of these problems, United Healthcare plays the shell game with the physician, challenging the physician to demonstrate that the patient is indeed insured. This activity violates a number of the the Insurance Code provisions set forth above, and additionally violates:

- a. 10 California Code of Regulations §2695.11. This regulation requires insurers to provide both claimant and assignee with an explanation of benefits that includes, among other things, "a clear explanation of the computation of benefits".
- b. Insurance Code §§10123.13 and 10123.147. These sections require insurers to include on the physician's explanation of benefits or remittance advice the fact that the physician may seek review by the DOI if the insurer contests or denies any portion of a claim.

#### Violation of Covenant of Good Faith and Fair Dealing

Further, the activity as a whole violates the covenant of good faith and fair dealing implied in all contracts, including health coverage policies. The duty of good faith, in this context, requires that UnitedHealthcare act consistently with the reasonable expectations of insureds, in this case patients. In the health care context, courts have safeguarded the rights of patients to be afforded the benefits of their coverage, and have viewed patients' reasonable expectations broadly. See *Sarchett v. Blue Shield of California* (1987) 43 Cal.3d 1, 13, 233 Cal.Rptr. 76. As a result, a health insurer that fails to pay claims accurately, and who misleads patients as to the participating status of physicians, frustrates the reasonable expectations of patients and breaches the duty of good faith.





# California Medical Association

Established 1856

March 13, 2007

Gary Baldwin  
Senior Counsel  
Department of Managed Health Care  
980 Ninth Street, Suite 500  
Sacramento, CA 95814-2725

Re: United Healthcare Non-participating Laboratory Services Protocol

Dear Mr. Baldwin:

On behalf of the California Medical Association ("CMA"), we respectfully request that the Department of Managed Health Care prohibit United Healthcare from implementing the attached protocol which purports to impose financial penalties on physicians whose patients go to out-of-network laboratories. For all the following reasons, we believe this policy is illegal and improperly interferes in the rights of patients to access the provider of their choice. While we understand that United Healthcare is not currently implementing this policy with respect to its DMHC regulated products, we believe the issue is of sufficient significance to warrant alerting the DMHC now.

Health plans, including United Healthcare's affiliate PacifiCare, are governed by several laws that significantly restrict their ability to influence a physician's professional medical judgment. First, Health & Safety Code §1348.6 expressly prohibits health plans from maintaining a financial incentive program which includes a:

"... specific payment made directly, in any type of form, to a physician, physician group, or other licensed health care practitioner as an inducement to deny, reduce, limit or delay specific medically necessary, and appropriate services provided with respect to a specific enrollee or group or group of enrollees with similar medical conditions."

Second, Health & Safety Code §1342(a) expresses the Legislature's intent to ensure "the continued role of the professional as the determiner of the patient's health needs which fosters the traditional relationship of trust and confidence between the patient and the professional." Third, Health & Safety Code §1367(g) requires health plans to "be able to demonstrate to the Department that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management."

Headquarters: 1201 J Street, Suite 200, Sacramento, CA 95814-2906 • 916.444.5532

San Francisco office: 221 Main Street, Suite 580, San Francisco CA 94105-1930 • 415.541.0900

Gary Baldwin  
United Healthcare Non-participating Laboratory Services Policy  
March 13, 2007  
page 2

These statutes clearly prohibit health plans from going beyond providing financial incentives to patients to use in network providers, to imposing financial penalties on physicians based on their patients' choices to go outside the network. Thus, the United Healthcare non-participating laboratory protocol, which purports to give United Healthcare the right to impose a \$50 fine, decrease the fee schedule, prejudice the physician's eligibility for the "Premium Designation and Practice Rewards" programs or even terminate the physician based on such patient choices, violates the Knox-Keene Act.

These sections are buttressed by several other provisions designed to ensure that health plans do not improperly interfere with a physician's professional medical judgment, the physician-patient relationship or the patients' right to make decisions concerning their healthcare. Apart from the law that requires physician participation contracts to be fair and reasonable, Health & Safety Code §1367(h), the laws specifically protecting physicians from retaliation for communications with their patients and other patient advocacy, Business & Professions Code §§510, 2056 and 2056.1, all apply to health plans. Eliminating any doubt as to the Legislature's commitment to these protections, since January 1, 2003, health plans have been expressly prohibited from including in their provider contracts any provision that waives or conflicts with these or any other provision of the Knox-Keene Act. *See* Health & Safety Code §1375.7.<sup>1</sup>

Understanding the significant financial implications for their patients that may arise from the use of out-of-network providers, contracting physicians routinely let their patients know about, and work hard to help them receive, in-network services. However, it is simply not the case that, with respect to each patient, the most qualified or most convenient physician or health facility is contracted with every health plan. Patients have the right to decide where to receive health care services, without having to worry that their physicians are being fined or otherwise penalized for their choices. This right is particularly acute when they pay premiums for an out-of-network benefit. Concomitantly, physicians have the right to speak freely with their patients about their health care choices, without having to worry that they will be fined or otherwise penalized should their patients choose an out-of-network option.

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<sup>1</sup> To the extent this protocol creates incentives for referral beyond those authorized by the Knox-Keene Act, we also believe it violates Business & Professions Code §650, which prohibits payments for the referral of patients.

Gary Baldwin  
United Healthcare Non-participating Laboratory Services Policy  
March 13, 2007  
page 3

For all the foregoing reasons, we respectfully urge the Department to prohibit United Healthcare from implementing the attached "Protocol on the Use of Non-Participating Laboratory Services" with respect to any health plan product in California. Please do not hesitate to contact me if you have any questions concerning this letter or the complaints CMA has received concerning United Healthcare.

Sincerely,

Catherine I. Hanson  
Vice President & General Counsel

et/CIH

Enclosure:

Cc: Joe Dunn  
Aileen Wetzel  
Frank Navarro  
Jodi Black

EX. 5040

STATE OF CALIFORNIA  
Steve Poizner, Insurance Commissioner

STATE OF CALIFORNIA  
Arnold Schwarzenegger, Governor

**DEPARTMENT OF INSURANCE**

David Link, Deputy Commissioner  
3100 Capitol Mall, Suite 1700  
Sacramento, CA 95814  
(916) 492-3612  
(916) 445-5280 (Fax)  
[www.insurance.ca.gov](http://www.insurance.ca.gov)

**DEPARTMENT OF MANAGED HEALTH CARE**

Lucinda A. Ehnes, Director  
989 9<sup>th</sup> Street, 8<sup>th</sup> Floor  
Sacramento, CA 95814  
(916) 323-8176  
(916) 323-2533 (Fax)  
[www.dmhca.ca.gov](http://www.dmhca.ca.gov)



May 17, 2007

Joseph Dunn  
Executive Vice President and CEO

Catherine I. Hanson  
Vice President and General Counsel  
California Medical Association  
1201 J Street  
Sacramento, CA 95814

RE: Your March 27, 2007 Letter regarding United Healthcare/PacificCare

Dear Ms. Hanson and Mr. Dunn,

Thank you for bringing your concerns to the California Department of Insurance (CDI) and the Department of Managed Health Care (DMHC). Your letter supplements information gathered from our own internal operations, and as a result, we have decided to conduct investigations, which are now underway. We are looking into a wide range of conduct by these companies and will use the full array of investigative and enforcement mechanisms available to us.

CDI and DMHC will be working jointly and coordinating our investigative efforts to the maximum extent possible. While we each have our own statutory and regulatory frameworks and will operate within those, there is much we can do together to make the process more efficient and the outcome more meaningful.

If we find violations of the law, we will be seeking all appropriate and available remedies. Our number one objective will be to bring the regulated entities into compliance for the benefit of both California providers and consumers in the near and long term.

We hope we can call on you for future assistance as we may need it. Thank you again for bringing your concerns to our attention.

Sincerely,

Handwritten signature of David Link in black ink.

David Link  
Deputy Commissioner, Legislative Director  
California Department of Insurance

Handwritten signature of Ed Heidig in black ink.

Ed Heidig  
Deputy Director  
Department of Managed Health Care





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**From:** Nozaki, Janet [jnozaki@dmhc.ca.gov]  
**Sent:** Wednesday, June 06, 2007 7:22 PM  
**To:** Vandepas, Coleen  
**Cc:** David, Towanda; Dixon, Craig; Dougherty, Agnes  
**Subject:** RE: PacifiCare

Hi Coleen,

You're welcome. I hope we will have more opportunities to work together. Good luck on your exam!

*Janet Nozaki, CPA*  
Supervising Examiner  
Department of Managed Health Care  
Office of Health Plan Oversight  
Division of Financial Oversight  
(213) 576-7612 voice  
(213) 576-7186 fax

---

**From:** Vandepas, Coleen [mailto:CVandepas@insurance.ca.gov]  
**Sent:** Tuesday, June 05, 2007 4:56 PM  
**To:** Nozaki, Janet; Dougherty, Agnes  
**Cc:** David, Towanda; Dixon, Craig  
**Subject:** PacifiCare

Dear Agnes & Janet:

Thank you for allowing me to attend your opening meetings with PacifiCare yesterday and today. You provided me with a great opportunity to review PacifiCare systems prior to the commencement of my exam. I am sure information I was able to pick-up during the meetings will be of great use in my review and analysis of the PPO business.

I appreciate the courtesy and professionalism you both extended and thank you for allowing me to participate in your exam.

Kind Regards,

Coleen Vandepas  
Associate Insurance Compliance Officer  
Field Claims Bureau  
213.346.6521  
cvandepas@insurance.ca.gov

CDI00001674





---

**From:** Vandepas, Coleen  
**Sent:** Saturday, June 23, 2007 12:02 AM  
**To:** Dinius-Bellotti, Elaine; Johnsen, Eric  
**Subject:** FW: PCLIC Exam

FYI...

---

**From:** Nozaki, Janet [mailto:jnozaki@dmhc.ca.gov]  
**Sent:** Fri 6/22/2007 4:40 PM  
**To:** Dixon, Craig  
**Cc:** Laucher, Joel; Rosen, Andrea; Vandepas, Coleen; David, Towanda  
**Subject:** RE: PCLIC Exam

Hi Craig,

We are extending our examination into July 2007 because of all the issues we are finding.

I understand a written confidentiality agreement is being signed between our two departments to share information. I will be happy to share our preliminary findings with you and your staff after the agreement is signed.

We would like attend your entrance meeting with the Plan since we found significant discrepancies in what the Plan told us at our entrance meeting that Coleen attended.

We would prefer to meet at the Plan's administrative office in Cypress the week of July 9th since we will be working there that week.

Have a great weekend!

-----Original Message-----

**From:** Dixon, Craig [mailto:DixonC@insurance.ca.gov]  
**Sent:** Thursday, June 21, 2007 3:39 PM  
**To:** Nozaki, Janet  
**Cc:** Laucher, Joel; Rosen, Andrea; Vandepas, Coleen; David, Towanda  
**Subject:** PCLIC Exam

Hello Janet, we were discussing our preparations for the upcoming CDI examination of PCLIC et.al. commencing the week of July 9th and it was suggested that we meet with you and those staff you feel would be appropriate. We would like to discuss your preliminary findings (to help us avoid unnecessary duplication of effort) and identify issues we may need to drill down on. Would it be possible to have a meeting the week of the 9th and could we possibly meet here in L.A.? Thank you Janet!

CDI00250129





**INFORMAL MEETING WITH DMHC EXAMINERS**  
**7/17/07**

CDI  
Towanda David  
Coleen Vandepas

DMHC  
Janet Noksaki, Supervisor  
Agnes Dougherty, Examiner-in-Charge

Directions to Coleen -- Meet at 9:15 a.m.

405 S. Exit Pacific (First Long Beach Exit which is right after 710)

Drive down 2 miles on Pacific [will past Wardlow (at a light), will past

Spring (at a light)] to 28<sup>th</sup>. Make a right and then an immediate Left on

To 2744 CEDAR. Drive down to middle of Block - green/ blue house with fountain

And Yellow Fire Hydrant.

Cell# (562) 260-8895 H# (562) 424-4484

HOF'S HUT  
10900 Los Alamitos Blvd  
Los Alamitos 90720  
Telephone (562) 799-9552

.....  
Hi Craig,

Yes, that will work. Have a nice weekend!

-----Original Message-----

From: Dixon, Craig [mailto:DixonC@insurance.ca.gov]

Sent: Thursday, July 12, 2007 7:05 PM

To: Nozaki, Janet

Cc: Vandepas, Coleen; David, Towanda; Dougherty, Agnes

Subject: RE: Meeting next week?

Janet, we would like to meet with all of you at 10 A.M. on the 17th at Hof's Hut. Please confirm with me, thanks! Craig

-----  
From: Nozaki, Janet [mailto:jnozaki@dmhc.ca.gov]

Sent: Thu 07/12/07 3:46 PM

To: Dixon, Craig

Cc: Vandepas, Coleen; David, Towanda; Laucher, Joel; Dougherty, Agnes

Subject: RE: Meeting next week?

Hi Craig,

CDI00034278

Tuesday, Wednesday or Thursday are dates that we can meet with you and your staff. Any time after 10:00 a.m. is good and before 4:00 p.m. is good for us. We can meet at Hof's Hut located at the corner of Katella and Los Alamitos since we are working at the Plan that week.

---

From: Dixon, Craig [mailto:DixonC@insurance.ca.gov]  
Sent: Thu 7/12/2007 3:18 PM  
To: Nozaki, Janet  
Cc: Vandepas, Coleen; David, Towanda; Laucher, Joel  
Subject: Meeting next week?

Janet, can you and your staff meet with us next week? If so, can you give us a couple dates and times? I suggest we allow a couple hours for this to discuss details of your interim report and its formulation as well as your experiences at PLIC/UHIC. Thanks!

Very Truly Yours,

Craig Dixon

Field Claims Bureau

(213) 346-6510

dixonc@insurance.ca.gov

CDI00034279

# Meeting with DMHC 7/17/07

Janet Nakmali - SVP  
Agnes = Examiner  
Dougherty

Chris Pilled  
SO - Renewal  
500 sample

Request Log  
Date Request  
Request #  
Crime Date usually 2 days

Interim Report - Exam with B Credits  
4 months ago 8/15

Running Log of all issues

REVA: she took the list  
Asked for resolution - DATE Requested  
-- Any REBUTALS.

LATE Payments - Transfer Claim for me to another  
Private Divorces  
Jury tried to Reconcile  
By paying payments with  
Interest.

-- Some Document 1143  
-- 8 out Account

Certificate of creditable Change - Issues

Focus on Group only?

Preclude Disputes  
Advised Claim  
Overturn

\* PAID CLAIM = <sup>LOOK AT</sup> Change from High to Low  
SIT DOWN WITH PROCESSOR  
Set-up with A WEB Processor

non-Enforceable claim - will pay 70% of Billed  
charge

outsourcing = NOT FAMILIAR WITH Product  
STATE Requirements

Co. STAY Training ISSUES  
DMHC STAY SYSTEMS ISSUES

UNIT THAT PROCEEDS DISUPTED

CRB - Melissa Agony

INGUP A LIST OF ACCORDING

Dario Wickman - In charge of  
Integration for PUBLIC

Fixed are Band Aid  
COST ISSUE PER AGONY

They are hitting the wrong  
they meanfully Denied Claim

Denial Code = stratiff

# Pacific Directions

 **Sorry!** When printing directly from the browser your map may be incorrectly cropped. To print the entire map, try clicking the "Printer-Friendly" link at the top of your results page.



**START** 6232 La Tijera Blvd  
Los Angeles, CA 90056-1706, US

**END** 5995 Plaza Dr  
Cypress, CA 90630-5028, US

**Total Est. Time:**  
35 minutes

**Total Est. Distance:**  
31.35 miles

Maneuvers	Distance
 1: Start out going <b>SOUTHWEST</b> on LA TIJERA BLVD toward W 63RD ST.	0.3 miles
 2: Turn <b>RIGHT</b> onto W FAIRVIEW BLVD.	<0.1 miles
 3: Turn <b>LEFT</b> onto S LA CIENEGA BLVD.	0.9 miles
 4: Merge onto I-405 S via the ramp on the <b>LEFT</b> toward LONG BEACH.	26.5 miles
 5: Take CA-22 E toward GARDEN GROVE.	0.5 miles
 6: Take the exit toward VALLEY VIEW ST NORTH.	0.2 miles
 7: Turn <b>RIGHT</b> onto GARDEN GROVE BLVD.	0.1 miles
 8: Turn <b>RIGHT</b> onto VALLEY VIEW ST.	2.4 miles
 9: Turn <b>LEFT</b> onto PLAZA DR.	<0.1 miles
 10: End at 5995 Plaza Dr Cypress, CA 90630-5028, US	

**Total Est. Time:** 35 minutes    **Total Est. Distance:** 31.35 miles

405 - TO 605 N  
 1st Exit Katella/Willow  
 Make Rt onto Katella  
 Approx 5 miles on Katella  
 TO Valley View.  
 Make Lt onto Valley View  
 + 1st Lt onto Plaza DR.

 **Sorry!** When printing directly from the browser your map may be incorrectly cropped. To print the entire map, try clicking the "Printer-Friendly" link at the top of your results page.



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---

**From:** Dougherty, Agnes [adougherty@dmhc.ca.gov]  
**Sent:** Friday, July 20, 2007 7:56 PM  
**To:** Vandepas, Coleen  
**Cc:** Nozaki, Janet  
**Subject:** RE: DMHC Sample Document Request Log

We're glad if it helps. It was nice seeing you again also!

Agnes

---

**From:** Vandepas, Coleen [mailto:CVandepas@insurance.ca.gov]  
**Sent:** Fri 7/20/2007 12:02 PM  
**To:** Dougherty, Agnes  
**Cc:** David, Towanda; Dixon, Craig; Nozaki, Janet  
**Subject:** RE: DMHC Sample Document Request Log

Hi Agnes:

Thanks for sending a sample of your request log. I am planning to incorporate the use of this document in the United/PacifiCare exam.

I wanted to let you know that I genuinely appreciate the time you and Janet spent meeting with the FCB team on Tuesday. I am sure the insight provided will be of great benefit to our exam. I look forward to seeing you again.

Thank you,

Coleen Vandepas  
Associate Insurance Compliance Officer  
Field Claims Bureau  
213.346.6521  
cvandepas@insurance.ca.gov

-----Original Message-----

**From:** Dougherty, Agnes [mailto:adougherty@dmhc.ca.gov]  
**Sent:** Tuesday, July 17, 2007 6:31 PM  
**To:** Vandepas, Coleen  
**Subject:** DMHC Sample Document Request Log

Hi Coleen,

Here is a sample of our document request log as of 6-4-07. Please note that we usually send a more detailed request by email with the request # in the subject line. We maintain this log with summaries of the request in the description column.

It was nice to see you today.

Agnes

## Appendix of Exhibits to Offer of Proof





---

**From:** Nozaki, Janet [jnozaki@dmhc.ca.gov]  
**Sent:** Friday, July 20, 2007 9:59 PM  
**To:** Dixon, Craig  
**Cc:** Wright, Mark; Dougherty, Agnes; Dobberteen, Amy; Baldwin, Gary  
**Subject:** PacifiCare of California Preliminary Interim Report (Confidential)  
**Attachments:** PacifiCare Interim Report 7-16-07.doc

Hi Craig,

I need confirmation from you that CDI understands that the attached preliminary interim report of the non-routine examination of PacifiCare of California is being provided pursuant to the terms of a confidentiality agreement between CDI and DMHC. The DMHC is providing this report early with the understanding that the confidentiality agreement will be fully executed early next week. We will need all CDI personnel who are involved in sharing information with the DMHC to sign the agreement as well. Please call me if you have any questions. Thanks!

*Janet Nozaki, CPA*  
Supervising Examiner  
Department of Managed Health Care  
Office of Health Plan Oversight  
Division of Financial Oversight  
(213) 576-7612 voice  
(213) 576-7186 fax

**NOTICE TO RECIPIENT:** If you are not the intended recipient of this e-mail, you are prohibited from sharing, copying, or otherwise using or disclosing its contents. If you have received this e-mail in error, please notify the sender immediately by reply e-mail and permanently delete this e-mail and any attachments without reading, forwarding or saving them. Thank you.

CDI00252179





Arnold Schwarzenegger, Governor  
State of California  
Business, Transportation and Housing Agency

320 West 4<sup>th</sup> Street, Suite 880  
Los Angeles, CA 90013-1105  
(213) 576-7612  
(213) 576-7186 fax  
jnozaki@dmhc.ca.gov

July 16, 2007

Via Federal Express and e-Mail

## PRELIMINARY INTERIM REPORT

James Anthony Frey, Chairman of the Board  
**PACIFICARE OF CALIFORNIA**  
5995 Plaza Drive  
Cypress, CA 90630

**Re: NON-ROUTINE EXAMINATION OF PACIFICARE OF CALIFORNIA**

Dear Mr. Frey:

This is a preliminary interim report of a non-routine regulatory examination of the claims settlement and provider dispute resolution processes of PacificCare of California (the "Plan"). The Department of Managed Health Care (the "Department") conducted the review pursuant to Rule 1300.71.38 (m) (1) and Section 1382 (b) of the Knox-Keene Health Care Service Plan Act of 1975 ("Act").<sup>1</sup>

Section 1382 (c) states, "Reports of all examinations shall be open to public inspection, except that no examination shall be made public, unless the plan has had an opportunity to review the examination report and file a statement or response within 45 days of the date that the department provided the report to the plan. After reviewing the plan's response, the director shall issue a final report that excludes any survey information, legal findings, or conclusions determined by the director to be in error, describes compliance efforts, identifies deficiencies that have been corrected by the plan on or before the time the director receives the plan's response, and describes remedial actions for deficiencies requiring longer periods for the remedy required by the director or proposed by the plan."

Where requested, please comment and state the action taken to correct the noted deficiencies. Such corrective action should include the management position responsible for overseeing the corrective action, a description of the monitoring system implemented to ensure ongoing compliance with the corrective action, and the date corrective action has been implemented.

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<sup>1</sup> References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, *et seq.* References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Division 1 of Chapter 1, Title 28, and California Code of Regulations, beginning with Section 1300.43.

On June 4, 2007, the Department commenced a non-routine examination of the Plan. The purpose of the examination was to verify corrective actions made by the Plan in response to the Department's Preliminary Report dated September 30, 2005 regarding the Plan's Provider Dispute Resolution Mechanism. The Department accepted the Plan's electronically filed response on November 21, 2005. The Department issued a Final Report on December 29, 2005. The examination also reviewed the Plan's claims processing operations due to the disclosure of significant deficiencies during a site visit on February 7, 2007, and the corrective actions represented to the Department resulting from the site visit. In addition, the Department has received numerous complaints from providers regarding the Plan's claims settlement practices.

**The DMHC examination is currently in progress and the following are our preliminary findings:**

**SECTION I. COMPLIANCE ISSUES**

**A. CLAIM SETTLEMENT PRACTICES – “UNFAIR PAYMENT PATTERN”**

Section 1371 requires that if an uncontested claim is not reimbursed within 45 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 45 working day period. This Section also requires that all interest that has accrued shall be automatically paid. The penalty for failure to comply with this requirement shall be a fee of ten (\$10) dollars.

Section 1371.35 (b), which refers to claims resulting from emergency services, requires that if an uncontested claim is not reimbursed within 45 working days after receipt, the plan shall pay the greater of \$15.00 or interest at the rate of 15% per annum, beginning with the first calendar day after the 30 working day period. The penalty for failure to comply with this requirement shall be a fee of ten (\$10) dollars.

Rule 1300.71 (a) (8) provides guidance for establishing that a Plan has engaged in an unfair payment pattern. It states that a "demonstrable and unjust payment pattern" or "unfair payment pattern" means any practice, policy or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims.

***DEFICIENCIES***

The Plan self-reported to the Department, substantial processing errors in connection with its Point-of-Service (POS) Out-of-Network (OON) claims and its failure to properly integrate processing of these claims between its two systems, NICE and RIMS. The Plan has acknowledged that errors with these processes were the cause of claim payment delays, incorrect denials, and incorrect payments. Rework projects to remediate incorrectly processed claims began in February, 2007. Claims requiring rework were selected by the Plan from claims that were processed from April 1, 2006 to April 30, 2007. The Plan stated that the total affected claims identified were approximately 79,000 claims. The Plan initially stated that these claims were reprocessed and remediated prior to the start of this examination on June 4, 2007.

**The Department has determined that the numbers and types of deficiencies discovered in our examination demonstrate that this remediation effort was not adequate.**

Our preliminary examination findings disclosed that the Plan engaged in a demonstrable and unjust payment pattern as follows:

1. Rule 1300.71 (a)(8)(F) states that one of these unjust payment patterns is the failure to provide a provider with an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim consistent with section (d)(1) at least 95% of the time for the affected claims over the course of any three-month period.

The Plan incorrectly denied claims to providers as follows:

- We reviewed fifty (50) denied claims, randomly selected from the claims system the Plan uses to process Point-of-service (POS) claims, called "RIMS". Twenty (20) of these claims, or 40%, were denied incorrectly. Examples of incorrect denials included:

Sample No.	Claim No.	Reason for Incorrect Denial
RIMS-B D-11	77094827-01	Incorrectly denied for no authorization, but no authorization was needed. An authorization number was included on the claim.
RIMS-B D-18	76088564-01	Incorrectly denied as non-participating provider, but the provider was participating (contracted).
RIMS-B D-26	76047887-01	Incorrectly denied as "not a covered benefit", but was a covered benefit.
RIMS-B D-30	77004048-01	Incorrectly denied for member exceeding maximum number of treatments, but the member had not reached the maximum.
RIMS-B D-37	76046803-01	Incorrectly denied for claim not filed within filing deadline, but received date of the claim was incorrect and therefore the claim was filed prior to the deadline.

- We reviewed twenty-five (25) denied claims, randomly selected from the claim system the Plan uses to process HMO claims, called "NICE". Twenty-three (23) of these claims were denied as IPA/Medical Group financial responsibility; and therefore, they were redirected by the Plan to the IPA/Medical Group for processing. Five (5) of these redirected claims, or 21.7%, were denied incorrectly because they were out-of-area claims that were actually the financial responsibility of the Plan, and not the financial liability of the IPA/Medical Group.
- Our analysis of Point-of-Service (POS) claims denied from January 1, 2006 through June 14, 2007, noted a total of 40,784 denied claims of which 22,707, or 55.68%, were denied as duplicate claim submissions. Out of these 22,707, we noted that 14,842, or 65.4%,

were all denied in the month of April 2007. The Plan stated the reason for the high number of denials in the month of April 2007 was due to a reprocessing and remediation effort in connection with claim processing errors in their Point-of-Service claims system called "RIMS". To remediate the claim processing errors in the RIMS system, the Plan incorrectly denied claims that were previously paid. The Plan also incorrectly issued denial letters to the providers stating that the providers had submitted duplicate claims when they had not.

The Plan provided information that linked twenty-six of these denials included in our sample to a previously paid claim to demonstrate that although it had issued denial letters incorrectly, the denials could all be linked to a prior payment. However, this sample is not representative of the population of claims denied as duplicates. The Plan acknowledged that it should have internally denied the claims and avoided the issuance of incorrect denial letters to providers. In addition, six (6) denials, or 23%, had been processed incorrectly before the denial was issued because interest owed on these claim was not automatically paid prior to the denial and was not paid until after the Department selected them for further review.

2. Rule 1300.71 (a)(8)(K) states that one of these unjust payment patterns is the failure to reimburse at least 95% of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period.

The Plan failed to reimburse complete claims with the correct payment including the automatic payment of all interest as follows:

- We reviewed twenty-five (25) late paid claims from the HMO claims system, NICE. Four (4) of these claims, or 16%, did not pay interest correctly on the late payment as required by Sections 1371 and 1371.35. We noted that the reasons for the late payments were due to incorrect processing of the claim when it was initially received. Upon subsequent reprocessing, interest on the late adjustments were not paid and therefore, interest and the \$10 fee were owed on the following:

Sample No.	Claim No.	Days Late <sup>1</sup>	Reason for Late Payment
NICE LP-3	3362499210100092	209	Initially processed incorrectly as non-contracted provider claim. Upon reprocessing, failed to automatically pay interest.
NICE LP-4	3317463250300011	87	Initially processed using incorrect CMS fee schedule. Upon reprocessing, failed to automatically pay interest.
NICE LP-6	3345022510100007	151	Plan did not pay the greater of \$15 or 15% for this emergency claim in accordance with Section 1371.35.

<sup>1</sup> The Department is using the 64 calendar day standard adopted by ICE to calculate 45 working days.

Sample No.	Claim No.	Days Late <sup>1</sup>	Reason for Late Payment
NICE LP-7	3364930750300036	74	Initially processed claim using incorrect CMS fee schedule. Upon reprocessing, failed to automatically pay interest.

- We reviewed twenty-five (25) late paid claims from the Point-of-Service claims system, RIMS. Late payments on a substantial number of these claims resulted from the failure to properly transition Point-of-Service Out-of-Network claims from the Plan's NICE system to its RIMS system. The failure to process these claims was realized during the reprocessing and remediation effort that began in February 2007. Seventeen (17) of the twenty-five (25) late claims reviewed, or 68%, had substantial delays because claims information failed to be manually "re-keyed" to the RIMS system for adjudication after initially being processed in the NICE system. The average number of days to transition from NICE to RIMS for these seventeen claims was 126 days. Although, the Plan paid interest and the \$10 fee on these claims during its reprocessing and remediation effort, the interest amount was not correctly calculated for all of these claims. Three (3) late claims in our sample of 25, or 12%, were underpaid interest as follows:

Sample No.	Claim No.	Days Late <sup>2</sup>
RIMS-B LP-1	127702826501	84
RIMS-B LP-7	127705742501	76
RIMS-B LP-19	127700212001	143

- Rule 1300.71 (a)(8)(L) states that one of these unjust payment patterns is the failure to contest or deny a claim, or portion thereof, within the timeframes of section (h) and sections 1371 or 1371.35 of the Act at least 95% of the time for the affected claims over the course of any three-month period.

Our examination disclosed that the Plan failed to meet this requirement and did not report its processing turnaround times accurately to the Department pursuant to Rule 1300.71 (q). The Plan's March 31, 2007 Quarterly Claims Settlement Report to the DMHC reports 95.4% of all paid, denied and adjusted claims were processed within 45 working days. Based upon data extracts of paid and denied claims provided to the examiners for the quarter ending March 31, 2007, the Department calculated the turnaround time percentage in the NICE system for paid claims to be 90.6%. Although, the RIMS system processes less than 15% of the Plan's business, the turnaround time percentage was 37.7% for paid claims. The denied claims turnaround times in the NICE system was 98.81% and the denied claims turnaround times in the RIMS system was 32.74%. Except for the NICE system denied claims turnaround times, all other turnaround times do not comply with the Regulation. Although, the Plan reported its noncompliance as a footnote, it did not report its turnaround time accurately.

<sup>2</sup> By email dated June 13, 2007, the Plan was notified that the Department's current position is that a full service plan that offers a Knox-Keene POS product is to comply with the 45 working day requirement of Section 1371 and Rule 1300.71(g). Previously, the Department required a full service plan to comply with the 30 working day requirement of Rule 1300.71 (f) (1).

### ***REQUIRED ACTIONS***

**Due to the serious nature of these violations, the Department is issuing this interim report to require the Plan to immediately begin corrective actions to resolve the deficiencies cited above. In addition, the Plan is required to submit monthly status report on its corrective actions. The monthly status report should include a description of any new problem found by the Plan, a description of the root cause of the problem, and the action(s) taken by the Plan to correct the problem. The Plan is required to provide a copy of its revised policy and procedures with its response. Furthermore, the Plan is required to state the date of implementation, the management position(s) responsible for ensuring compliance and the controls implemented for monitoring continued compliance.**

**Additional findings and remediation actions will be included in the Preliminary Report that will be issued at the completion of this examination.**

### **B. PROVIDER DISPUTE RESOLUTION**

Rule 1300.71.38 states that all health care service plans and their capitated providers that pay claims (plan's capitated provider) shall establish a fast, fair and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes. This rule further states that each mechanism complies with sections 1367 (h), 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28.

Rule 1300.71.38 (f) requires the Plan to resolve each provider dispute or amended provider dispute, consistent with applicable state and federal law and the provisions of sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.37, 1371.4 and 1371.8 of the Health and Safety Code and section 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of title 28, and issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 working days after the date of receipt of the provider dispute or the amended provider dispute.

Our preliminary examination findings disclosed that the Plan failed to process provider disputes accurately and/or within the timeframes required. Our review of provider disputes is still in progress.

As of the date of this report, we completed a review of twenty-three (23) provider disputes that were randomly selected. Five (5) of these or 21.7% were processed late because they were not resolved within forty-five (45) working days. Six (6) of these or 26% were processed incorrectly because the Plan did not resolve the dispute correctly.

The following are examples:

PDR No.	Claim No.	Incorrect determination and/or Late Resolution
NICE - PDR-1	2232334-03-007	Although claim was received with medical records including discharge summary, trauma run, trauma history and physical, final radiologic test results - trauma, ER physician orders, trauma flow sheet, interdisciplinary notes, and daily order summary in accordance with provider agreement, the claim was not paid at trauma rates. The Plan issued incorrect determinations. Provider submitted 3 disputes as a result of incorrect determinations.
NICE - PDR-3	2374572-03-008	Claim was contested for missing medical records although letter issued by Plan did not specify medical records required to process claim at trauma level of care. Multiple disputes were received. Second dispute received on 10/17/06 had the required medical records but was not resolved/ paid correctly nor timely.
NICE - PDR-10	7033050-01-014	Dispute was received with medical records on 9/26/06 as a result of a previous denial for no medical records. Incorrect determination because claim was denied as a duplicate and medical records were requested again on 11/2/06 and again on 12/6/06.
NICE - PDR-14	6558037-02-002	Dispute was received multiple times. Incorrect determinations resulted from documents related to the claim held in "Document DNA" queues that were not processed timely and late determinations/late payments resulted.
NICE - PDR-17	4740486-01-014	Dispute was not resolved timely. Payment of interest and penalties on the late payment was not made until 486 days from date of payment.

These preliminary findings demonstrate that the Plan issued incorrect determinations, requested medical records when they were not needed, or did not request records when they were needed to process the claim correctly. The Plan is also not in compliance with the dispute resolution turnaround times.

***REQUIRED ACTIONS***

**Due to the serious nature of these violations, the Department is issuing this interim report to require the Plan to immediately begin corrective actions to resolve the deficiencies cited above. In addition, the Plan is required to submit monthly status report on its corrective actions. The monthly status report should include a description of any new problem found by the Plan, a description of the root cause of the problem, and the action(s) taken by the Plan to correct the problem. The Plan is required to provide a copy of its revised policy and procedures with its response. Furthermore, the Plan is required to state the date of implementation, the management position(s) responsible for ensuring compliance and the controls implemented for monitoring continued compliance.**

**Additional findings and remediation actions will be included in the Preliminary Report that will be issued at the completion of this examination.**

**C. ADMINISTRATIVE CAPACITY**

Section 1367 (g) and Rule 1300.67.3 require that health care service plans maintain “the organizational and administrative capacity to provide services to subscribers and enrollees” and that a plan’s organization, administrative services, and policies must “result in the effective conduct of the plan’s business” and “provide effective controls.”

**DEFICIENCY**

Our examination disclosed that the Plan has not demonstrated that they have maintained the organizational and administrative capacity to provide services to subscribers and enrollees as follows:

1. The Plan has not demonstrated “effective controls” to oversee the claims processing functions<sup>3</sup> that it has delegated to the following affiliated<sup>4</sup> and non-affiliated entities:

Entity/Location	Contracting Party	Date implemented	Claim Functions
Lason Systems, Inc. /Utah	PHS	May 2006	Front end – Scanning and maintenance of scanned records.
PacifiCare International Limited (PIL) /Ireland	Plan	1999	Claim Processing – Adjudication for NICE (HMO & In-network POS) including: <ul style="list-style-type: none"> <li>• HMO stop loss claims</li> <li>• HMO chemo &amp; injectible claims</li> <li>• HMO rework claims</li> </ul>
PSO (TX) PSO merged with PHPA. PSO is sometimes used in reference to the Texas location for PHPA.	PHPA	May 2006	Claims Processing and Customer Service <ul style="list-style-type: none"> <li>• HMO transplant claim processing</li> <li>• HMO Recovery</li> <li>• POS Out-of-Network</li> </ul>
MedPlans Partners, Inc	PHS	May 2006	Claims Processing for POS Out-of-Network

All of the substantial deficiencies disclosed during the early stages of our examination and described in this report show that the Plan’s processes are insufficient to provide effective controls over the claim operations.

<sup>3</sup> This information was provided in this requested format to the DMHC examiners on June 26, 2007. PHS is PacifiCare Health Systems, LLC (Grandparent Co.). PHPA is PacifiCare Health Plan Administrators (Parent Co.)

<sup>4</sup> PHS is PacifiCare Health Systems, LLC (Grandparent company). PHPA is PacifiCare Health Plan Administrators (Parent company)

The Plan provided information regarding the oversight and monitoring it performs over these delegated processes but the Department found that this was not sufficient given all the claim processing problems disclosed in this examination.

In addition, we are still in the process of determining if the Plan has demonstrated effective controls to oversee the claim processing functions delegated to the following affiliated and non-affiliated entities:

Entity/Location	Contracting Party	Date implemented	Claim Functions
Health Network Systems	PHS	2003	Facility Pricing -Pricing based on Plan contract with provider for HMO and POS
Private Health Care Systems	PHPA	May 2006	Leased Rental Network used for POS Out-of-Network claims where the member resides outside of CA or for members who travel outside of CA
PHPA/Arizona	Plan	May 2006	Claims Processing HMO Medicare Secondary Payer
Concentra (2001)	PHPA	2001	Non-par UB claims >\$1k Outpatient; >\$5k Inpatient repricing

2. The Plan has not demonstrated that it has sufficient staffing and resources to manage its claims inventory. The Plan has stated that the backlog in the Plan's Point-of-Service claims inventory grew because staff and resources were redirected to address contract loading problems affecting their PPO (preferred provider organization) line of business under the PacifiCare Life Insurance Company (Department of Insurance licensee). This demonstrates the Plan's failure to address compliance problems as needed because of its inability to allocate resources and staffing to ensure compliance with the claim settlement requirements. The Department is still reviewing this issue.
3. The Plan failed to demonstrate that it can readily provide accurate contracts and contract information in order for the Department to review the payment accuracy of claims selected for our review. Thirteen (13) out of twenty-five (25) contracts or fee schedules were not provided timely and four (4) of these contracts could not be provided for the "RIMS-B Paid Sample" of claims selected for review for payment accuracy.

In addition, it was brought to the Department's attention through numerous complaints from providers that the Plan had failed to properly "load" provider contracts causing claims to be incorrectly paid. At the start of the examination, the Plan informed the Department that this problem did not affect lines of business under PacifiCare of California. However, later in the examination this assertion was retracted and the Plan informed the Department that this problem did impact the PPO network which is utilized in the Plan's Point-of Service product Tier 2 option. The Plan has also stated that the problem was corrected during its remediation effort. The Department is still reviewing this issue.

4. The Plan failed to demonstrate that it maintains adequate control over documents needed to process claims and provider disputes. These documents and other correspondence were delayed

in queues and were not processed timely. These delays negatively impacted the Plan's ability to pay its claims correctly and to meet claims processing turnaround time requirements. The correspondence in connection with claims and provider disputes such as medical records and letters of agreement were not reviewed timely and were held in queues within the correspondence tracking system called "Document DNA."

It is apparent that under the current organizational structure, it is impossible for the Plan to demonstrate that it is able to exercise independent control over its operations, provide adequate oversight of delegated functions, and to have adequate resources (including staffing) to properly perform its claim processing functions to ensure compliance with the Knox-Keene Act and Regulations.

**These issues are being referred to the Office of Enforcement for administrative action.**

### ***REQUIRED ACTION***

**The Plan is required to file an undertaking that all executive management (i.e., CEO, CFO, COO and Medical Director) and key staff (i.e., Director of Regulatory Compliance, Claims, Information Technology and clinical staff) are to be employed by the Plan and located at the Plan's administrative offices in California, unless the Plan can show to the satisfaction of the Department through a Corrective Action Plan (CAP), that adequate oversight, authority and responsibility are retained by the Plan. If the CAP is not fully completed at the time the Plan files its response, the Plan is to submit the reason and timeframe that the remaining corrective actions will be submitted to the Department.**

**The Plan is required to file an undertaking that the processing of POS claims will be returned from Texas to California by July 16, 2007, and performed by Plan employees.**

**The Plan is required to file an undertaking that it will employed sufficient staff in California to correct the deficiencies cited in this report, as well as other deficiencies found by the Plan, and to ensure that the Plan maintains compliance with the Knox-Keene Act and Title 28 Regulations at all times.**

**The Plan is required to file an undertaking that reflects a commitment by its Ultimate Parent Company that the Plan shall have all resources needed (including staffing, information technology systems and funding) to correct the deficiencies cited in this report and to ensure compliance with the Knox-Keene Act and Title 28 Regulations at all times.**

**As part of the CAP, the Plan will need to file revised administrative services agreements that it has with PHPA, its affiliated or non-affiliated entities to reflect changes in its operations and appropriate access to all, staffing, resources including information technology resources as needed to result in effective compliance with the Knox-Keene Act and Regulations.**

**The revised agreement(s) are to be filed electronically as amendment filings with the Department. The cover page for these filings should state that it is filed as a result of the recent financial examination. The Plan is requested reference in its response to this report that the**

**requested filing(s) have been submitted to the Department within 45 days after receipt of this report.**

**Additional findings and remediation actions will be include in the Preliminary Report that will be issued at the completion of this examination.**

#### **D. DATE OF RECEIPT**

Rule 1300.71 (a)(6) defines "Date of receipt" to mean the working day when a claim, by physical or electronic means, is first delivered to either the plan's specified claims payment office, post office box, or designated claims processor or to the plan's capitated provider for that claim. In the situation where a claim is sent to the incorrect party, the "date of receipt" shall be the working day when the claim, by physical or electronic means, is first delivered to the correct party responsible for adjudicating the claim.

#### ***DEFICIENCY***

Our examination reviewed the Plan's receipt process and data entry of claims. Paper POS claims are received at a Cypress Post Office box and sent overnight to Lason in Utah for scanning and input to the claim system. However, Lason is inputting the receipt date they receive the POS claims and not the receipt date that the POS claims are received at the Cypress Post Office box. This results in the inaccurate reporting of claim payment timeliness and results in underpayment of interest for late POS claims.

#### ***REQUIRED ACTION***

**The Plan is required to state the corrective action implemented to ensure that the actual receipt date is inputted into the claims system. The Plan is also required to provide a copy of its revised policy and procedures with its response. Furthermore, the Plan is required to state the date of implementation, the management position(s) responsible for ensuring compliance and the controls implemented for monitoring continued compliance.**

Please file the Plan's response electronically via the Department's eFiling web portal <<https://wps0.dmhc.ca.gov/secure/login/>>. From the main menu, select e-Filing. From the home menu, select File Documents. From the File Documents Menu 1) File Type, select Amendment to Prior Filing, 2) Original Filing No., select the Filing No. assigned by the Department. 3) Select create filing. From the Original Filing Details Menu, select "Plan's Response to Preliminary Interim Report (FE12)", upload amendments and then upload your response. Questions or problems related to the electronic transmission of the response should be directed to Siniva Pedro at (916) 322-5393 or email at [spedro@dmhc.ca.gov](mailto:spedro@dmhc.ca.gov). You may also email inquiries to [wps0@dmhc.ca.gov](mailto:wps0@dmhc.ca.gov).

If you have any questions with this report, please contact me.

James Anthony Frey, Chairman of the Board  
RE: Preliminary Interim Report of Non-Routine Examination of PacifiCare of California

File No. 933 0126  
Page 12

Sincerely,

JANET NOZAKI  
Supervising Examiner  
Office of Health Plan Oversight  
Division of Financial Oversight

cc: Susan Berkel, Chief Financial Officer, PacifiCare of California  
Mark Wright, Chief, Division of Financial Oversight  
Marcy Gallagher, Chief, Division of Plan Survey  
Linda Azzolina, Counsel, Division of Licensing  
Agnes Dougherty, Senior Examiner, Division of Financial Oversight  
Michelle Bland, Examiner, Division of Financial Oversight





Message

Page 1 of 1

**David, Towanda**

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**From:** David, Towanda  
**Sent:** Saturday, August 18, 2007 11:25 AM  
**To:** Johnsen, Eric  
**Cc:** Vandepas, Coleen  
**Subject:** RE: PLHIC Codes and Terminology

Eric,

Per our conversation, please re-work the Comparison Codes Checklist to include all DMHC issues identified in their Interim Draft Report.

Management expects that in our sample file review, we will see the same issues as DMHC identified in their report with respect to PLHIC claims handling.

Therefore, we have been directed to identify our statutes that correspond to DMHC codes so that we can provide the insurance side of each scenario

criticized by the DMHC. Any questions, let me know. I will have e-mail access while at Conseco in Indiana next week. You can reach me by telephone at

(317) 817-6654.

-Towanda

-----Original Message-----

**From:** Johnsen, Eric  
**Sent:** Friday, August 17, 2007 4:34 PM  
**To:** David, Towanda  
**Cc:** Vandepas, Coleen  
**Subject:** PLHIC Codes and Terminology

See attached updated codes and terminology for the PLHIC exam. (Entries in RED are new).

Eric Johnsen

8/18/2007

CDI00034391





No.	DMHC code	DOI code (CIC or CCR)	Description of citation
1	Sec. 1371	790.03(h)(5)	unfair payment pattern - interest on uncontested claim paid > 45 days
2	Rule 1300.71(a)(8)(F)	790.03(h)(13) or 2695.7(b)(1)	no clear, specific reason for delay, deny
3	Rule 1300.71(a)(8)	790.03(h)(5) or 2695.7(g)	delay or incorrect payment
4	Sec. 1371.35(b)	10123.147(b)	payment of emergency services DMHC - (45 days; \$15/day or 15%/yr interest). DOI - (30 days; \$15/day or 10%/yr interest).
5	Rule 1300.71(a)(8)(K)	790.03(h)(5) or 2695.7(g)	failure to reimburse claims, including interest.
6	Sec. 1367(g) and Rule 1300.67.3	2695.3(a)	providing copies of contracts to the Department
7	Rule 1300.71(a)(b)	2695.3(b)(2)	date of receipt of documents





**CALIFORNIA  
DEPARTMENT OF INSURANCE**

Return

## **NEWS: 2008 PRESS RELEASE**

For Release: January 29, 2008  
Media Calls Only: 916-492-3566

### **Commissioner Poizner and DMHC Director Ehnes Take Historic Joint Action Against PacifiCare to Halt Broken Claims Payment Systems**

More Than \$1 Million for Providers and Consumers Recovered, Millions of Dollars in Additional Penalties Sought, Permanent Cure of Broken Claim Handling Systems

#### **DMHC Media Contact: Lynne Randolph 916-396-4100 or 916-445-7442**

SAN FRANCISCO/ LOS ANGELES □ Insurance Commissioner Steve Poizner and Cindy Ehnes, Director of the California Department of Managed Health Care (DMHC), today announced a joint action against PacifiCare companies, owned by UnitedHealth Group, in response to more than 130,000 alleged claims handling violations. This joint endeavor is an historic step in the efforts of both the California Department of Insurance (CDI) and DMHC to put an end to the practice of unfair claims handling in the health insurance industry. This collaborative effort is the first action ever by both CDI and DMHC against a single health plan or insurer.

After receiving hundreds of consumer and provider complaints about claims payment problems by PacifiCare, particularly after it was acquired by United Healthcare in late 2005, CDI and DMHC took action and launched a joint investigation in 2007 into PacifiCare's alleged unfair practices. California law specifies that CDI generally regulates PPO (provider-preferred organization) health products and DMHC regulates HMO (health-maintenance organization) products.

"When they're injured or ill consumers rely on their insurers to pay legitimate claims," said Insurance Commissioner Steve Poizner. "This promise is essential to our health care system, so after years of broken promises to Californians, it is crystal clear that PacifiCare simply can not or will not fix the meltdown in its claims paying process. We're going to put an end to that. If PacifiCare can't carry out the ABCs of basic claims payment, today's regulatory action will help spell it out."

"The most fundamental purpose of insurance is the promise to pay claims fairly and on time and PacifiCare has broken this promise," said Cindy Ehnes, Director of the DMHC. "We're taking strong action today to make sure patients and providers are treated fairly so that they are able to continue to take care of California's health care needs."

PacifiCare's alleged violations cited by CDI and DMHC include:

- Wrongful denials of covered claims
- Incorrect payment of claims
- Lost documents including certificates of creditable coverage and medical records
- Failure to timely acknowledge receipt of claims
- Multiple requests for documentation that was previously provided
- Failure to address all issues and respond timely to member appeals and provider disputes
- Failure to manage provider network contracts and resolve provider disputes

5272

CDI also directed a self-audit of PacifiCare's unfair pre-existing condition denials, resulting in \$765,157 in claims and recoveries for consumers and providers. As a result of this CDI investigation, more than \$1 million has already been recovered for California consumers and health providers who were impacted by PacifiCare's alleged violations.

CDI market conduct examinations revealed that PacifiCare allegedly made large scale and willful decisions to use broken systems to process claims and respond to providers, while continually and effectively collecting premiums. CDI discovered PacifiCare's alleged unlawful conduct last year while investigating consumer complaints and then confirmed PacifiCare's failure to fix its systems during a targeted market conduct examination which revealed the full extent of alleged misconduct. CDI's investigation exposed PacifiCare's alleged decision to improperly handle claims which resulted in thousands of infractions and grossly unfair treatment of policyholders and providers.

CDI's market conduct examinations reviewed PacifiCare files processed between July 1, 2005 and May 31, 2007, and have identified 130,000 violations of law by PacifiCare in its claims handling practices and handling of provider data including tracking of provider disputes and maintaining network lists. Statutory penalties are provided for up to \$5,000 for each non-willful violation of law and up to \$10,000 for each willful violation of law. The enforcement action Commissioner Poizner has brought against PacifiCare thus potentially implicates up to \$650 million if all violations are proved and shown to be non-willful and up to \$1.3 billion if all violations are proved and shown to be willful. Only a few days ago, the company admitted that it expects to lose at least 400,000 customers nationally due to poor customer service.

Similar provider claims payment violations have been established by the DMHC and the plan has been assessed a penalty of \$3.5 million, the largest fine imposed by the DMHC. The DMHC fine differs from the CDI amount because it is calculated based on a set of standards set by law, not on a per violation formula. In addition, the DMHC has set out certain steps the company must take to correct the claims payment problems, including an independent monitor to oversee changes and additional staff to handle the workload.

The CDI enforcement action is attached. The DMHC report can be found at [www.dmhc.ca.gov](http://www.dmhc.ca.gov).

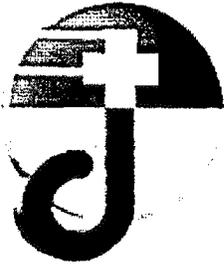
Order to Show Cause for PacifiCare. Market Conduct Exam can be found [here](#).

###

Please visit the Department of Insurance Web site at [www.insurance.ca.gov](http://www.insurance.ca.gov). Non media inquiries should be directed to the Consumer Hotline at 800.927.HELP. Callers from out of state, please dial 213.897.8921. Telecommunications Devices for the Deaf (TDD), please dial 800.482.4833.

If you are a member of the public wishing information, please visit our [Consumer Services](#).





Arnold Schwarzenegger, Governor  
State of California  
Business, Transportation and Housing Agency

**Department of Managed Health Care**  
320 West Fourth Street, Suite 880  
Los Angeles, CA 90013  
213-576-7612 voice  
213-576-7186 fax  
[jnozaki@dmhc.ca.gov](mailto:jnozaki@dmhc.ca.gov) - e-mail

January 16, 2008

Via Electronic Mail and FedEx Delivery

David M. Hansen, Chairman of the Board  
**PACIFICARE OF CALIFORNIA**  
5995 Plaza Drive  
Cypress, CA 90630

**RE: FINAL REPORT OF THE NON-ROUTINE EXAMINATION OF PACIFICARE OF CALIFORNIA**

Dear Mr. Hansen:

Enclosed is the Final Report of the non-routine examination of PacifiCare of California (the "Plan"). The Department of Managed Health Care (the "Department") conducted the examination pursuant to Rule 1300.71.38 (m) (1) and Section 1382 (b) of the Knox-Keene Health Care Service Plan Act of 1975 ("Act").<sup>1</sup> The Department issued an Interim Preliminary Report to the Plan on July 16, 2007 and a Preliminary Report on September 28, 2007. The Department accepted the Plan's response to the Interim Preliminary Report on August 30, 2007 and the Plan's response to the Preliminary Report on November 14, 2007. The Department also received monthly status reports for the months of September, October and November 2007 from the Plan on the progress of its corrective action plan.

This Final Report includes a description of the compliance efforts included in the Plan's August 30, 2007 and November 14, 2007 responses, along with information received in the monthly status reports from the Plan, in accordance with Section 1382 (c).

Section 1382 (d) states "If requested in writing by the plan, the director shall append the plan's response to the final report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and provide modified copies to the department for public distribution not later than 10 days from the date of notification from the department that the final report will be made available to the public. The addendum to the response or statement shall also be made available to the public."

Please indicate within ten (10) days whether the Plan requests the Department to append its response to the Final Report. If so, please indicate which portions of the Plan's response shall be appended and provide electronically those portions of the Plan's response exclusive of

<sup>1</sup> References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, *et seq.* References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Division 1 of Chapter 1, Title 28, and California Code of Regulations, beginning with Section 1300.43.

information held confidential pursuant to Section 1382 (c), no later than ten (10) days from the date of the Plan's receipt of this letter.

If the Plan requests the Department to append an addendum response or brief statement summarizing the Plan's August 30, 2007 and/or November 14, 2007 responses to the report or wishes to modify any information provided to the Department in its responses, please provide the electronically filed documentation no later than ten (10) days from the date of the Plan's receipt of this letter through the eFiling web portal. Please file this addendum or statement electronically via the Department's eFiling web portal at <https://wpsso.dmhc.ca.gov/secure/login/> as follows:

- From the main menu, select "eFiling".
- From the eFiling (Home) menu, select "File Documents".
- From the File Documents Menu for:
  - 1) File Type; select "Amendment to prior filing";
  - 2) Original Filing, select the Department's assigned "Filing No. 20071897" by clicking on the down arrow; and
  - 3) Click "create filing".
- From the Original Filing Details Menu, click "Upload Amendments"; select # of documents; select document type: "Plan addendum response to Final Report (FE5)"; then "Select File" and click "Upload".
- Upload all documents then upload a cover letter as Exhibit E-1 that references to your response. After upload, then select "Complete Amendment",
- Select a "Signatory,"
- Complete "Execution" and then click "complete filing".

As noted in the attached Final Report, the Plan's August 30, 2007 and November 14, 2007 responses did not fully resolve the deficiencies noted and the corrective actions required in the Preliminary Interim Report dated July 16, 2007 and the Preliminary Report dated September 28, 2007. Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for the corrective action requested in the Final Report, within thirty (30) days after receipt of the report.

Please file the Plan's response to the Final Report electronically via the Department's eFiling web portal <https://wpsso.dmhc.ca.gov/secure/login/>, as follows:

- From the main menu, select "eFiling".
- From the eFiling (Home) menu, select "File Documents".
- From the File Documents Menu for:
  - 1) File Type; select "Amendment to prior filing";
  - 2) Original Filing, select the Department's assigned "Filing No. 20071897" by clicking on the down arrow; and
  - 3) Click "create filing".
- From the Original Filing Details Menu, click "Upload Amendments"; select # of documents; select document type: "Plan's Response to Final Report (FE10)"; then "Select File" and click "Upload".
- Upload all documents then upload a cover letter as Exhibit E-1 that references to your response. After upload, then select "Complete Amendment",

- Select a "Signatory,"
- Complete "Execution" and then click "complete filing".

Questions or problems related to the electronic transmission of the response should be directed to Siniva Pedro at (916) 322-5393 or email at [spedro@dmhc.ca.gov](mailto:spedro@dmhc.ca.gov). You may also email inquiries to [wpsa@dmhc.ca.gov](mailto:wpsa@dmhc.ca.gov).

**The Department will make the attached Final Report available to the public in ten (10) days from the Plan's receipt of the letter.**

If you have any questions regarding this report, please contact me.

Sincerely,

JANET NOZAKI  
Supervising Examiner  
Office of Health Plan Oversight  
Division of Financial Oversight

ad/sm:jn

cc: Susan Berkel, Chief Financial Officer, PacifiCare of California  
Mark Wright, Chief, Division of Financial Oversight  
Marcy Gallagher, Chief, Division of Plan Survey  
Linda Azzolina, Counsel, Division of Licensing  
Susan Miller, Examiner, Division of Financial Oversight  
Lorilee Ambrosini, Examiner, Division of Financial Oversight

**CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE  
DIVISION OF FINANCIAL OVERSIGHT**

**FINAL REPORT OF THE NON-ROUTINE EXAMINATION OF  
PACIFICARE OF CALIFORNIA**

**FILE NO. 933 0126**

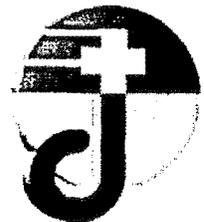
**DATE OF FINAL REPORT: JANUARY 16, 2008**

**SUPERVISING EXAMINER: JANET NOZAKI**

**EXAMINER-IN-CHARGE: AGNES DOUGHERTY**

**FINANCIAL EXAMINERS:**

**GALAL GADO  
MARIA MARQUEZ  
LISA MEDINA  
SUSAN MILLER**



## BACKGROUND INFORMATION FOR PACIFICARE OF CALIFORNIA

Date Plan Licensed: March 28, 1975

Organizational Structure: PacifiCare of California, Inc. was incorporated as a nonprofit health maintenance organization in 1975 and converted to for-profit status in 1984. The Plan is a wholly owned subsidiary of PacifiCare Health Plan Administrators, Inc. ("PHPA"). PHPA is a wholly owned subsidiary of PacifiCare Health Systems, LLC, (Parent) formerly PacifiCare Health Systems, Inc. Effective December 20, 2005, the Parent became a wholly owned subsidiary of UnitedHealth Group Incorporated.

Type of Plan: The Plan is a full service plan and arranges for comprehensive health care services to its enrollees of commercial group subscribers, small group subscribers, point-of-service subscribers, and Medicare beneficiaries under the Medicare + Choice program through contracts with the Centers for Medicare & Medicaid Services.

Provider Network: The Plan provides health care services by contracting with participating medical groups on a capitated basis, as well as direct contracts with individual physicians on a discounted fee-for-service basis. Hospitals are compensated on a capitated, per diem or case rate basis. Specialty care is arranged through the participating medical group network of contracted specialists.

Plan Enrollment: 1,587,566 enrollees as of September 30, 2007.

Service Area: The service area consists of all major counties in California.

Date of Last Public Routine Financial Examination Report: March 23, 2005

## FINAL REPORT OF THE NON-ROUTINE EXAMINATION OF PACIFICARE OF CALIFORNIA

This is the Final Report of the non-routine examination of PacifiCare of California (the "Plan"). The Department of Managed Health Care (the "Department") conducted the examination pursuant to Rule 1300.71.38 (m) (1) and Section 1382 (b) of the Knox-Keene Health Care Service Plan Act of 1975 ("Act").<sup>1</sup> The Department issued an Interim Preliminary Report to the Plan on July 16, 2007 and a Preliminary Report on September 28, 2007. The Department accepted the Plan's response to the Interim Preliminary Report on August 30, 2007 and the Plan's response to the Preliminary Report on November 14, 2007. The Department also received monthly status reports for the months of September, October and November 2007 from the Plan on the progress of its corrective action plan.

On June 4, 2007, the Department commenced a non-routine examination of the Plan. The purpose of the examination was to verify corrective actions made by the Plan in response to the Department's Preliminary Report dated September 30, 2005 regarding the Plan's Provider Dispute Resolution Mechanism. The examination also reviewed the Plan's claims processing operations due to the disclosure of significant deficiencies during a site visit on February 7, 2007 by the Department, and the corrective actions represented to the Department resulting from the site visit. In addition, the Department has received numerous complaints from providers regarding the Plan's claims settlement practices.

On July 16, 2007, the Department issued a Preliminary Interim Report prior to the completion of the non-routine examination due to findings of substantial violations that required the Plan to immediately begin corrective actions to resolve the deficiencies. To resolve the issues disclosed in the Department's Preliminary Interim Report, the Plan filed a response on August 30, 2007 which documented its corrective actions.

This Final Report includes a description of the compliance efforts included in the Plan's August 30, 2007 and November 14, 2007 responses, along with information received in the monthly status reports from the Plan, in accordance with Section 1382 (c). The Plan's responses are noted in *italics*. Our findings are presented in the accompanying attachment as follows:

- Section I. Compliance Issues
- Section II. Non-routine Examination

*Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for the corrective action requested in this report, within 30 days after receipt of this report.*

---

<sup>1</sup> References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, *et seq.* References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Division 1 of Chapter 1, Title 28, and California Code of Regulations, beginning with Section 1300.43.

## SECTION I. COMPLIANCE ISSUES

### A. CLAIM SETTLEMENT PRACTICES – “UNFAIR PAYMENT PATTERN”

Section 1371 requires that if an uncontested claim is not reimbursed within 45 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 45 working day period. This Section also requires that all interest that has accrued shall be automatically paid. The penalty for failure to comply with this requirement shall be a fee of ten (\$10) dollars.

Section 1371.35 (b), which refers to claims resulting from emergency services, requires that if an uncontested claim is not reimbursed within 45 working days after receipt, the plan shall pay the greater of \$15.00 or interest at the rate of 15% per annum, beginning with the first calendar day after the 30 working day period. The penalty for failure to comply with this requirement shall be a fee of ten (\$10) dollars.

Rule 1300.71 (a) (8) provides guidance for establishing that a Plan has engaged in an unfair payment pattern. It states that a "demonstrable and unjust payment pattern" or "unfair payment pattern" means any practice, policy or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims.

The Plan self-reported to the Department, substantial processing errors in connection with its Point-of-Service (POS), Out-of-Network (OON) claims and its failure to properly integrate processing of these claims between its two claim systems, NICE and RIMS. The Plan has acknowledged that errors with these processes were the cause of claim payment delays, incorrect denials, and incorrect payments. Rework projects to remediate incorrectly processed claims began in February, 2007. Claims requiring rework were selected by the Plan from claims that were processed from April 1, 2006 to April 30, 2007. The Plan stated that the total affected claims identified were approximately 79,000 claims. The Plan initially stated that these claims were reprocessed and remediated prior to the start of this examination on June 4, 2007.

**The Department has determined that the numbers and types of deficiencies discovered in our examination demonstrate that the Plan’s remediation effort was not adequate.**

Our preliminary examination findings (reported in the Department’s Preliminary Interim Report dated July 16, 2007) found that the Plan is engaged in a demonstrable and unjust payment pattern as follows:

1. Rule 1300.71 (a)(8)(F) states that one of these unjust payment patterns is the failure to provide a provider with an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim consistent with section (d)(1) at least 95% of the time for the affected claims over the course of any three-month period.

The Plan incorrectly denied claims to providers as follows:

- We reviewed fifty (50) denied claims, randomly selected from the claims system the Plan uses to process Point-of-service (POS) claims, called "RIMS". Twenty (20) of these claims, or 40%, were denied incorrectly. Examples of incorrect denials included:

Sample No.	Claim No.	Reason for Incorrect Denial
RIMS-B D-11	77094827-01	Incorrectly denied for no authorization, but no authorization was needed. An authorization number was included on the claim.
RIMS-B D-18	76088564-01	Incorrectly denied as non-participating provider, but the provider was participating (contracted).
RIMS-B D-26	76047887-01	Incorrectly denied as "not a covered benefit", but was a covered benefit.
RIMS-B D-30	77004048-01	Incorrectly denied for member exceeding maximum number of treatments, but the member had not reached the maximum.
RIMS-B D-37	76046803-01	Incorrectly denied for claim not filed within filing deadline, but received date of the claim was incorrect and therefore the claim was filed prior to the deadline.

- We reviewed twenty-five (25) denied claims, randomly selected from the claim system the Plan uses to process HMO claims, called "NICE". Twenty-three (23) of these claims were denied as IPA/Medical Group financial responsibility; and therefore, they were redirected by the Plan to the IPA/Medical Group for processing. Five (5) of these redirected claims, or 21.7%, were denied incorrectly because they were out-of-area claims that were actually the financial responsibility of the Plan, and not the financial liability of the IPA/Medical Group.
- Our analysis of Point-of-Service (POS) claims denied from January 1, 2006 through June 14, 2007, noted a total of 40,784 denied claims of which 22,707, or 55.68%, were denied as duplicate claim submissions. Out of these 22,707, we noted that 14,842, or 65.4%, were all denied in the month of April 2007. The Plan stated the reason for the high number of denials in the month of April 2007 was due to a reprocessing and remediation effort in connection with claim processing errors in their Point-of-Service claims system called "RIMS". To remediate the claim processing errors in the RIMS system, the Plan incorrectly denied claims that were previously paid. The Plan also incorrectly issued denial letters to the providers stating that the providers had submitted duplicate claims when they had not.

The Plan provided information that linked twenty-six of these denials included in our sample to a previously paid claim to demonstrate that although it had issued denial letters incorrectly, the denials could all be linked to a prior payment. However, this sample is not representative of the population of claims denied as duplicates. The Plan acknowledged that it should have internally denied the claims and avoided the issuance

of incorrect denial letters to providers. In addition, six (6) denials, or 23%, had been processed incorrectly before the denial was issued because interest owed on the claim was not automatically paid prior to the denial and was not paid until after the Department selected them for further review.

2. Rule 1300.71 (a)(8)(K) states that one of these unjust payment patterns is the failure to reimburse at least 95% of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period.

The Plan failed to reimburse complete claims with the correct payment including the automatic payment of all interest as follows:

- We reviewed twenty-five (25) late paid claims from the HMO claims system, NICE. Four (4) of these claims, or 16%, did not pay interest correctly on the late payment as required by Sections 1371 and 1371.35. We noted that the reasons for the late payments were due to incorrect processing of the claim when it was initially received. Upon subsequent reprocessing, interest on the late adjustments were not paid and therefore, interest and the \$10 fee were owed on the following:

Sample No.	Claim No.	Days Late <sup>1</sup>	Reason for Late Payment
NICE LP-3	3362499210100092	209	Initially processed incorrectly as non-contracted provider claim. Upon reprocessing, failed to automatically pay interest.
NICE LP-4	3317463250300011	87	Initially processed using incorrect CMS fee schedule. Upon reprocessing, failed to automatically pay interest.
NICE LP-6	3345022510100007	151	Plan did not pay the greater of \$15 or 15% for this emergency claim in accordance with Section 1371.35.
NICE LP-7	3364930750300036	74	Initially processed claim using incorrect CMS fee schedule. Upon reprocessing, failed to automatically pay interest.

- We reviewed twenty-five (25) late paid claims from the Point-of-Service claims system, RIMS. Late payments on a substantial number of these claims resulted from the failure to properly transition Point-of-Service Out-of-Network claims from the Plan's NICE system to its RIMS system. The failure to process these claims was realized during the

<sup>1</sup> The Department is using the 64 calendar day standard adopted by ICE to calculate 45 working days.

reprocessing and remediation effort that began in February 2007. Seventeen (17) of the twenty-five (25) late claims reviewed, or 68%, had substantial delays because claims information failed to be manually "re-keyed" to the RIMS system for adjudication after initially being processed in the NICE system. The average number of days to transition from NICE to RIMS for these seventeen claims was 126 days. Although, the Plan paid interest and the \$10 fee on these claims during its reprocessing and remediation effort, the interest amount was not correctly calculated for all of these claims. Three (3) late claims in our sample of 25, or 12%, were underpaid interest as follows:

Sample No.	Claim No.	Days Late <sup>2</sup>
RIMS-B LP-1	127702826501	84
RIMS-B LP-7	127705742501	76
RIMS-B LP-19	127700212001	143

The Department's Preliminary Interim Report required the Plan to immediately begin corrective actions to resolve the deficiencies cited above. In addition, the Plan was required to submit a monthly status report on its corrective actions. The monthly status report was to include a description of any new problem found by the Plan, a description of the root cause of the problem, and the action(s) taken by the Plan to correct the problem. The Plan was required to provide a copy of its revised policy and procedures with its response. Furthermore, the Plan was required to state the date of implementation, the management position(s) responsible for ensuring compliance and the controls implemented for monitoring continued compliance.

**The Plan's August 30, 2007 response is summarized below:**

*The Plan acknowledged that twenty (20) POS claims were inappropriately denied. The Plan's corrective actions included:*

***Adjudication of POS Claims***

***1. Centralizing all POS claims processing in Cypress, California.***

*The Plan stated that it began the transition of POS claims processing to Cypress, California on July 9, 2007. They stated that the transition plan will be completed by December 31, 2007, including POS claims reprocessing.*

*The Plan also provided the following Table to show the revised process compared to the process in place during the Department's examination.*

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<sup>2</sup>By email dated June 13, 2007, the Plan was notified that the Department's current position is that a full service plan that offers a Knox-Keene POS product is to comply with the 45 working day requirement of Section 1371 and Rule 1300.71(g). Previously, the Department required a full service plan to comply with the 30 working day requirement of Rule 1300.71 (f) (1).

	<i>Newly Revised Process</i>	<i>Old Process</i>
<i>Location of Staff Processing In-network Claims</i>	<i>Cypress, California</i>	<i>Letterkenney, Ireland</i>
<i>Location of Staff Processing Out-of-network Claims</i>	<i>Cypress, California</i>	<i>MedPlans Partners, Inc (claims processing vendor)</i>
<i>Identification of out of network claims for processing.</i>	<i>Cypress, California</i>	<i>Letterkenney, Ireland</i>
<i>Entry of out of network claims for processing.</i>	<i>San Antonio, Texas</i>	<i>Lason (scanning and data entry vendor)</i>
<i>Information System Used for In-network Claims</i>	<i>NICE</i>	<i>NICE</i>
<i>Information System Used for Out-of-network Claims</i>	<i>RIMS</i>	<i>RIMS</i>

Based on the implementation of the above changes, the Plan stated that it expects to improve its POS claims processing turn around times. The POS turn around times will be based on a 45 working day calculation, consistent with HMO and as discussed with the Department. The Plan stated that it expects to be in compliance with ABI455 claims processing for the fourth quarter of 2007; but for the POS calculations, the Plan stated that claims paid and denied within 45 working days will improve from 75% at October 2007 to 95% at December 2007.

2. Retraining all POS claims examiners by August 31, 2007.

The Plan stated that all Cypress POS claims examiners attended training on August 22, 2007. The session included specific training around the audit findings, including how to:

- confirm if an authorization is required, and if it is, how to match to that authorization,
- confirm that the correct provider contract has been selected,
- confirm if the service is a covered benefit, and
- confirm the number of treatments allowed and if services to date are within the limit.

3. Enhancing POS reporting by November 1, 2007.

The Plan stated that to ensure that all claims denied in NICE for out of network claims adjudication are appropriately entered into RIMS, the Plan will implement daily reporting that compares the number of NICE POS claims denials to those entered into RIMS. The Plan will also implement a cumulative error report that lists those POS claims denied in NICE that were not subsequently entered into RIMS. The Plan will implement these reports by November 1, 2007 and will include a sample report in the monthly reporting to the Department by December 1, 2007. In addition, the Plan will continue its weekly reporting of POS claims turn around times and processing volumes and will also include those results in the monthly reporting to the Department by November 1, 2007.

4. *Implementing self-audits of POS denied claims by October 1, 2007 to confirm that errors are being mitigated.*

*To ensure improved performance of POS claim denials, the Plan stated that it will conduct a weekly self-audit of fifty (50) POS denied claims to confirm that each denial was appropriate. The weekly self-audit will begin by October 1, 2007 and will end December 31, 2007, if the Plan determines that weekly self-audits are no longer necessary.*

*The self-audit will be conducted by internal staff dedicated to quality oversight of operations. This team is independent of the POS claims processing team and reports to a different management team within UnitedHealthcare. The Plan believes it is appropriate to engage this team for this purpose, as it represents a separation of duties and management that will contribute to the objectivity of the self-auditing process. The audit results will be reported to the POS claims team on an ongoing basis and the Plan's Vice President of Transactions Oversight will review the audit results on a monthly basis. These audit results will be included in the monthly reporting to the Department by December 1, 2007.*

5. *POS Rework Project And Associated Inappropriate Denials.*

*The Plan acknowledged that approximately 23,000 POS out-of-network claims were inappropriately reprocessed, then denied as duplicates, and denial letters issued, when the claims had been previously paid. The Plan believes that the inappropriate duplicate denials were caused by the unique circumstances of the POS reprocessing project and will not be a recurring issue.*

*In February 2007, the Plan self-reported to the Department that not all POS claims had been paid correctly. The Plan had not appropriately transferred out-of-network POS claims to San Antonio for processing on RIMS. To ensure that all impacted claims were identified for reprocessing, certain claims were entered into RIMS that had been previously paid. Therefore, when the claim was reprocessed in RIMS, the claim was identified as a duplicate and a denial explanation of payment (EOP) for duplicate claim was issued. The Plan acknowledged that the provider did not submit a duplicate claim and that a denial EOP should not have been sent. The Plan had previously paid all claims and these should not have been reprocessed.*

*As of July 26, 2007, the Plan stated that it had implemented a corrective action that causes a POS claim that is inappropriately entered into RIMS a second time to be denied as a "no pay" claim. The Plan stated that the "no pay" denial will not generate an EOP. A claim is considered to have been inappropriately entered into RIMS if it was paid based on the initial claim submission and the provider has not resubmitted the claim.*

***Adjudication of HMO Claims***

*The plan acknowledged that five HMO claims were inappropriately denied as IPA/medical group financial responsibility when they were actually out of area claims that were the financial*

*responsibility of the Plan. The Plan's corrective actions included:*

*1. Correction to out of area determination function.*

*On May 31, 2007, the Plan implemented a correction to the out of area mileage determination function within its NICE claims processing system. Prior to that fix, the system was not consistently performing the appropriate mileage calculation which contributed to certain claims being deemed "in-area" when they were actually for services received "out of area," and therefore the Plan's payment responsibility.*

*2. Reporting on Claims returned to capitated IPA/medical groups.*

*The Plan stated that it will produce weekly specific provider-level trend reporting on paid claims that were initially determined to be the financial liability of the IPA/medical group. As necessary, the Plan will implement an action plan for those providers that show an unusual amount of group return activity. The Plan will research the root cause behind such fluctuation and will take steps to resolve issues timely, including reviewing contract language and terms, if necessary. The Plan stated that it's Vice President of Transactions Oversight will review the trend reports on a monthly basis and the results will be included in the monthly reporting to the Department as of November 1, 2007.*

*Calculation of Interest and Penalties*

*1. Corrective Action for RIMS Interest.*

*The Plan acknowledged that six of 26 sampled POS out-of-network claims payments did not include the required interest. Claims examiners relied on RIMS to systematically calculate and pay the interest. The interest did not systematically calculate by RIMS because the claim was manually entered directly into RIMS. The Plan stated that manual entry, instead of batch processing, bypasses the programming that pays interest on late claims. The practice of manually entering a claim directly into RIMS should occur on an exception basis and only for certain escalated issues. In addition, the following corrective actions were taken:*

- The Plan issued a training bulletin on August 28, 2007 to emphasize that claims are to be entered into RIMS directly on an exception only basis. A separate training bulletin was issued on August 14, 2007 that included the details of the correct manual calculation of interest. Copies of these training bulletins are included with the Plan's response.*
- The Plan will implement focused audit procedures related to accurate interest payments on those claims that are entered manually into RIMS. These self-audits will begin by October 1, 2007 and will end December 31, 2007, unless the Plan determines that continued auditing is necessary. Self-audits will be conducted by internal staff dedicated to quality oversight of operations. This team is independent of the POS claims*

*processing team and reports to a different management team within UnitedHealthcare. The Plan believes it is appropriate to engage this team for this purpose, as it represents a separation of duties and management that will assure the objectivity of the self-auditing process. The Plan's Vice President of Transactions Oversight will review the results on a monthly basis. The results will be included in the monthly reporting to the Department by December 1, 2007.*

2. *Corrective Action for HMO Late Paid Claims and Interest & Penalty.*

*The Plan agreed that 4 of the 25 HMO late paid claims did not pay interest correctly. The following corrective actions were taken:*

- The Plan stated that it had updated its Interest Application Policy and Procedure on July 25, 2007 to specifically address the emergency room interest rate calculation. The Plan provided updated training on this topic to the claims processing staff via team meetings. The Manager of HMO Claims Processing issued an updated policy update. A copy of this updated policy was included with the Plan's response.*
- The Plan stated that it would implement weekly self-audit procedures of late HMO claims payments to ensure that interest and penalties are being calculated correctly. The Plan stated that self-audits will begin by October 1, 2007 and will end December 31, 2007, unless the Plan determines that continued auditing is necessary. The Plan stated that self-audits will be conducted by internal staff dedicated to quality oversight of operations. This team is independent of the HMO claims processing team and reports to a different management team within UnitedHealthcare. The Plan believes it is appropriate to engage this team for this purpose, as it represents a separation of duties and management that will assure the objectivity of the self-auditing process. The Plan's Vice President of Transactions Oversight will review the results on a monthly basis. The results will be included in the monthly reporting to the Department as of December 1, 2007.*
- The Plan's Vice President of Transactions Oversight will also review fee schedule update reports on a monthly basis to confirm that CMS fee schedules are updated timely upon receipt from CMS. The results will be included in the monthly reporting to the Department by December 1, 2007.*

*As previously stated, the Plan has updated the number of calendar days in its RIMS programming as of August 25, 2007 to align with the Department's final interpretation of converting the legally required 45 working days into 64 calendar days. This will mitigate the overpayment of interest on future claim payments.*

*In summary, the Plan stated that all corrective actions described in Section A, except where noted, are being overseen by the Vice President of Transactions Oversight located in Cypress, California. The Plan stated that it will submit a monthly status report for the month ended*

*September 30, 2007 to the Department beginning November 1, 2007. The report will include progress on items included in the response above and other items necessary to demonstrate the Plan's progress. The Plan will also provide information related to ongoing self-audit results, including root cause remediation.*

The Plan's September 6, 2007 response stated that it disagreed with the Department's findings that three (3) of the twenty-five (25) RIMS late paid claims underpaid interest. The Plan stated that three (3) claims were initially considered underpaid by the Department because its testing used 60 calendar days in the calculation instead of the standard 64 calendar days. The Plan subsequently paid the additional interest as calculated and requested by the Department. This conclusion was incorrect because the Department did not use 60 calendar days in the calculation.

The Plan requested the Department to cease further examination of denied claims in accordance with the Department's statistical sampling procedures in exchange for an Acknowledgement, executed by the Plan on August 10, 2007, that the issues the Department identified in its operations and claims payment systems were found to violate the Knox-Keene Act and Rule 1300.71 (a)(8) (F).

The Plan also requested the Department to cease further examination of late claims in exchange for an Acknowledgement, executed by the Plan on August 10, 2007, that the issues the Department identified in its operations and claims payment systems were found to violate the Knox-Keene Act and Rule 1300.71 (a)(8) (K).

The following are additional claim findings not reported in the Preliminary Interim Report:

- The Department reviewed a total of one hundred (100) denied claims, randomly selected from the claims system the Plan uses to process Point-of-service (POS) claims, called "RIMS". Thirty-nine (39) of these claims, or 39%, were denied incorrectly. The Department's Preliminary Interim Report reported similar findings after review of the first fifty (50) of these denied claim sample of one hundred (100) denied claims. The findings for the remaining sample were the same.
- On July 18, 2007, subsequent to the issuance of the Preliminary Interim Report, the Plan notified the Department that the denied file extract for NICE claims provided to the DMHC on June 4, 2007, was incomplete. A new data extract was provided and a replacement 50 NICE denied claims were selected and review. The findings of this review were similar to the findings reported in the Preliminary Interim Report because ten (15) of fifty (50) or 30% were denied incorrectly. The majority of incorrect denials were because the Plan believed the claims to be the responsibility of the IPA/Medical Group when they were actually the Plan's responsibility.

**All of the above violations were referred to the Office of Enforcement for administrative action.**

The Department reviewed the Plan's August 30, 2007 response to the Interim Preliminary Report and the Corrective Action Plan (CAP) included in the response. The Department noted that the CAP included weekly self-audits of POS denied claims to confirm that each denial was appropriate. The Plan stated that weekly self-audits are to begin by October 1, 2007 and end December 31, 2007, if the Plan determines that weekly self-audits are no longer necessary. This corrective action does not provide sufficient detail about the methods used to determine if a denial is appropriate, the type of reporting that will be issued to document results of the audit, minimum and maximum number of errors to be used for determining acceptable levels and the measurements used to determine if the audits will continue or will be discontinued completely.

The Plan stated that for claims incorrectly returned to IPA/Medical Groups it will implement an action plan for those providers that show an unusual amount of group return activity. The Plan stated that it will research the root cause behind such fluctuation and will take steps to resolve issues timely, including reviewing contract language and terms, if necessary. This corrective action appears to focus on those providers that have high levels of group returns. It does not address incorrect group return activity for incorrect reasons and for groups who do not have high levels of returns. It also fails to include a review process by the Plan to ensure that these claims are forwarded to and paid by the IPA/Medical group after redirection. Our reviews found that several of the providers did not receive the redirected claim and this was not disclosed until after we requested the post-redirection review.

The Plan also stated that to ensure the correct payment of interest and penalties on late POS and HMO claims, it will implement weekly self-audit procedures of late HMO and POS claim payments to ensure that interest and penalties are being calculated correctly. The Plan stated that self-audits will begin by October 1, 2007 and will end December 31, 2007, unless the Plan determines that continued auditing is necessary. This corrective action does not provide sufficient detail about the type of reporting that will be issued to adequately document results of the audit, minimum and maximum number of errors to be used for determining acceptable levels and the measurements used to determine if the audits will continue on a limited basis or will be discontinued completely.

The Plan was required to revise its CAP to address the issues above and to complete the following additional corrective actions:

The Plan was required to review all late paid claims and all late adjustments resulting from provider disputes, during the period December 1, 2005 through the date of the Plan's response to this report, to determine whether interest was paid correctly in accordance with Rule 1300.71 (a)(8)(K), Sections 1371 and 1371.35.

For those late payments where interest was not paid or underpaid, the Plan was required to submit a detailed CAP to bring the Plan into compliance with the above requirements that should include, but not be limited to, the following:

- a. Identification of those claims and provider disputes requiring remediation.

b. Evidence that interest and \$10 fee, as appropriate, were paid retroactively for the claims identified in paragraph "a" above. This evidence was to include an electronic data file/schedule (ACCESS) that identifies the following:

- Claim number
- Date original claim received
- Date new information received (date claim was complete)
- Total billed
- Original total paid
- Original paid date
- Amount of adjustment paid (w/ check number)
- Date adjustment paid
- Amount of original interest paid
- Original interest paid date
- Amount of additional interest paid (w/ formula)
- Number of Days Late Used to Calculate Interest (w/ formula)
- Date additional interest paid
- \$10 fee paid
- Date \$10 fee paid
- Check number for interest and/or penalty
- Provider name
- ER or Non-ER indicator

The data file was to provide the detail of all claims remediated; and, to include the total number of claims and the total additional interest and \$10 fee paid, as a result of remediation.

If the Plan was unable to complete remediation by the due date of the response to this report, the Plan was required to submit a timeline that is no longer than one year from the due date which reflects progress and completion of the remediation. In addition, the Plan shall submit monthly status reports to the Department until the remediation is completed.

**The Plan's November 14, 2007 response is summarized below:**

*The Plan responded that its weekly self audits of POS denials are performed based upon a random sample of fifty denied POS claims. They are evaluated against the Plan's standard claims processing policies and procedures to determine whether a denial was appropriate. The audit procedures include, but are not limited to, confirming use of the correct receipt date when a claim is denied for timely filing, confirming use of the correct schedule of benefits when a claim is denied for "not a covered benefit" and confirming the necessity of an authorization when a claim is denied for "no authorization". The Plan's self-audits are evaluated against the Claims Payment Accuracy (CPA) measurement. This performance measure is defined as the "percent of claims without financial errors." The Plan's success standard for the CPA*

*measurement is 97%. Therefore, if the Plan achieves a success rate of 97% or higher for the cumulative audit results for the period October 1, 2007 to December 31, 2007, the Plan will no longer deem it necessary for the focused audits to continue. However, POS denials will continue to be included in the Plan's standard monthly quality audits. In its monthly reporting, the Plan has developed comprehensive reporting of its self-audit results which include the audit results, the details of the sample and any corrective actions taken, if applicable.*

*The Plan's ongoing or planned corrective actions included the following:*

- Re-adjudicating claims processed incorrectly from February 9, 2007 to May 31, 2007 because the out of area determination programming was inaccurate. Remediation timing will be determined by December 14, 2007.*
- Implementing a process to capture and identify root cause on all paid claims that were initially determined to be the financial liability of the IPA/medical group by February 1, 2008.*
- Hiring six additional staff to research root cause issues, address provider specific issues and re-directed claim procedures and implement related process changes/corrective actions by February 1, 2008. The recruiting process has begun for these additional positions.*

*The Plan responded that its weekly self-audits of the correct payment of interest and penalties on late HMO and POS claims are performed based upon a random sample of fifty late paid POS claims and fifty late paid HMO claims. They are evaluated against the Plan's standard claims processing policies and procedures to determine whether the interest and penalty were applied appropriately. The Plan's self-audits are evaluated against the Claims Payment Accuracy (CPA) measurement. This performance measure is defined as the "percent of claims without financial errors." The Plan's success standard for the CPA measurement is 97.00%. Therefore, if the Plan achieves a success rate of 97.00% or higher for the cumulative audit results for the period October 1, 2007 to December 31, 2007, the Plan will no longer deem it necessary for the focused audits to continue. However, the application of HMO and POS interest and penalty on late paid claims will continue to be included in the Plan's standard monthly quality audits.*

*The Plan also has developed comprehensive reporting of the self-audit results which include the audit results, the details of the sample and any corrective actions taken, if applicable.*

*The Plan stated it will review all late paid claims and all late adjustments during the period December 1, 2005 through November 14, 2007 to determine whether interest was paid appropriately. The Plan is in the process of performing a quality review of the report detailing the claims to be reviewed for possible remediation to ensure its accuracy. The Plan estimates completion of the quality review by December 14, 2007. After the quality review is complete, the Plan will determine the remediation timing and will provide updates to that work plan in the monthly reporting to the Department. The Plan will provide all evidence as noted above.*

**The Department finds that the Plan's compliance efforts are not fully responsive to the deficiencies cited and corrective actions required. The Plan's response did not include an action plan to address incorrect group return activity for incorrect reasons and for groups who do not have high levels of returns. It also failed to include a review process by the Plan to ensure that these claims are forwarded to and paid by the IPA/Medical group after redirection. The Plan is required to submit an action plan to address these two issues.**

**The Plan is required to maintain an ongoing monitoring process of the separate payment areas and systems to timely determine root causes of inappropriate interest payment before they become systemic. In addition, the Plan is required to continue its monitoring process for a sufficient length of time (i.e. additional six months) after compliance levels are achieved to demonstrate ongoing compliance.**

**In its November 2007 monthly status report to the Department, the Plan reported that a Vice President of Transactions Oversight was hired. Due to the significant responsibilities that this individual will hold, the Plan is required to submit the qualification and experience of the individual hired with its response to this report.**

**The Department acknowledges that the Plan anticipates that its remediation efforts will be completed by August 2008 as reported in its November 2007 status report. In addition, the Department acknowledges that 95% compliance may not be achieved by the Plan until remediation is complete because of the remediation's impact on the compliance percentage. However, the Plan is required to submit evidence of its remediation efforts on a monthly basis. These monthly status reports are due within 15 days following the close of each month. The first status report will be due on February 15, 2008, listing individually by claim all interest and penalties paid up to January 31, 2008. The status report should be submitted through the Department's eFiling web portal, as described in the cover letter, until the remediation is fully completed. Large remediation files can be submitted directly to the Department on a CD with an E-1 filing submitted through the web portal stating that the remediation file was submitted directly to the Department on a CD.**

## **B. PROVIDER DISPUTE RESOLUTION**

Rule 1300.71.38 states that all health care service plans and their capitated providers that pay claims (plan's capitated provider) shall establish a fast, fair and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes. This rule further states that each mechanism complies with sections 1367 (h), 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28.

Rule 1300.71.38 (f) requires the Plan to resolve each provider dispute or amended provider dispute, consistent with applicable state and federal law and the provisions of sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.37, 1371.4 and 1371.8 of the Health and Safety Code and section 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of title 28, and issue a written

determination stating the pertinent facts and explaining the reasons for its determination within 45 working days after the date of receipt of the provider dispute or the amended provider dispute. Our preliminary examination findings (reported in the Department's July 17, 2007 Preliminary Interim Report) found that the Plan failed to process provider disputes accurately and/or within the timeframes required.

As of July 17, 2007, we had completed a review of twenty-three (23) provider disputes. Five (5) of these or 21.7% were processed late because they were not resolved within forty-five (45) working days. Six (6) of these or 26% were processed incorrectly because the Plan did not resolve the dispute correctly.

The following examples were provided:

PDR No.	Claim No.	Incorrect determination and/or Late Resolution
NICE - PDR-1	2232334-03-007	Although claim was received with medical records including discharge summary, trauma run, trauma history and physical, final radiologic test results - trauma, ER physician orders, trauma flow sheet, interdisciplinary notes, and daily order summary in accordance with provider agreement, the claim was not paid at trauma rates. The Plan issued incorrect determinations. Provider submitted three disputes as a result of incorrect determinations.
NICE - PDR-3	2374572-03-008	Claim was contested for missing medical records although letter issued by Plan did not specify medical records required to process claim at trauma level of care. Multiple disputes were received. Second dispute received on 10/17/06 had the required medical records but was not resolved/ paid correctly nor timely.
NICE - PDR-10	7033050-01-014	Dispute was received with medical records on 9/26/06 as a result of a previous denial for no medical records. Incorrect determination because claim was denied as a duplicate and medical records were requested again on 11/2/06 and again on 12/6/06.
NICE - PDR-14	6558037-02-002	Dispute was received multiple times. Incorrect determinations resulted from documents related to the claim held in "Document DNA" queues that were not processed timely and late determinations/late payments resulted.
NICE - PDR-17	4740486-01-014	Dispute was not resolved timely. Payment of interest and penalties on the late payment was not made until 486 days from date of payment.

These preliminary findings demonstrate that the Plan issued incorrect determinations, requested medical records when they were not needed, or did not request records when they were needed to process the claim correctly. The Plan was also not in compliance with the dispute resolution turnaround times.

The Department's Preliminary Interim Report required the Plan to immediately begin corrective actions to resolve the deficiencies cited above. In addition, the Plan was required to submit monthly status reports on its corrective actions. The monthly status reports were to include a description of any

new problem found by the Plan, a description of the root cause of the problem, and the action(s) taken by the Plan to correct the problem. The Plan was required to provide a copy of its revised policy and procedures with its response. Furthermore, the Plan was required to state the date of implementation, the management position(s) responsible for ensuring compliance and the controls implemented for monitoring continued compliance.

**The Plan's August 30, 2007 response is summarized below:**

*The Plan acknowledged the Department's findings. The Plan's ongoing or planned corrective actions included:*

- 1. A complete review of the Provider Dispute Resolution (PDR) process. The work plan for this review was submitted with the Plan's response.*
- 2. PDR will be monitored by the Vice President of Transactions Oversight, a new position based in Cypress, California that reports to the Plan President.*
- 3. A monthly status report on the Plan's PDR corrective actions will be submitted to the Department beginning November 1, 2007. The monthly report will include any new problems identified, the root causes and the corrective action plans.*

*The Plan stated that from July 16, 2007 to date, in addition to review meetings supporting the items noted above, the Plan has:*

- Identified the need for additional staffing. The Plan is recruiting ten positions for the Cypress, CA based PDR team.*
- Identified the need for additional staffing to perform functions to address member and physician inquiries and problem resolution.*
- Begun flowcharting PDR intake sources and data flows.*

The Plan requested the Department to cease further examination of provider disputes in accordance with the Department's statistical sampling procedures in exchange for an Acknowledgement, executed by the Plan on August 10, 2007, that the issues the Department identified in its provider dispute resolution procedures, operations, tracking system (called REVA) and related finalization processes in its NICE and RIMS claim systems were found to violate Rule 1300.71.38.

The following are additional provider disputes findings not reported in the Preliminary Interim Report but reported in the Preliminary Report:

- The Department reviewed forty-nine (49) overturned provider disputes in total. Fourteen (14) or 29% were resolved incorrectly for reasons that were similar to the ones reported*

in the interim preliminary report based upon a review of the first twenty-three (23) in our sample of forty-nine (49).

- Fourteen (14) or 29% of the forty-nine (49) overturned provider disputes reviewed were late because they were not processed within forty-five (45) working days as required by Rule 1300.71.38 (f).
- Eleven (11) or 22% of the forty-nine (49) overturned provider disputes reviewed had letters sent to the provider requesting information that was not needed to process the claim or requested the wrong information.
- Six (6) or 30% of twenty (20) upheld provider disputes reviewed had incorrect determination letters or inaccurate determination letters.
- Our review disclosed that incorrect determinations and incorrect determination letters often resulted because there was no process for ensuring that after review of the PDR by a PDR researcher, results of the review documented in the REVA system were interpreted correctly by the claim processor who was responsible for finalizing the claim and issuing the PDR determinations.
- Our review also disclosed that when a provider called about a claim dispute that the provider filed with the Plan, the Customer Service unit who received the call was not able to transfer the call to anyone in the claims processing unit or the provider dispute unit so that the provider dispute and claim history can be accessed by someone who can assist the provider with the dispute. The Customer Service unit merely instructs the provider to submit another dispute. We noted that many of the provider disputes review had multiple disputes associated with their claim dispute.
- The Plan also acknowledged that the Plan's PDR tracking system called REVA included claim projects submitted by providers at the Plan's request and/or initiated by the Provider. These "projects" included provider disputes and also first-time claim submissions. The Plan was not able to distinguish between first-time submissions and those claims submitted as a dispute. As a result, the Plan was not able to capture accurate PDR statistics for reporting to the Department in accordance with the requirements of Rule 1300.71.38 (k) "Annual Plan Claims Payment and Dispute Resolution Mechanism Report."

**All of the above violations were referred to the Office of Enforcement for administrative action.**

The Plan was required to submit a CAP that includes revisions to its operations and policies and procedures that will include but are not limited to the additional provider dispute findings noted above, and that will ensure provider disputes are processed accurately and timely in accordance with the requirements of Rule 1300.71.38.

*The Plan's November 14, 2007 response is summarized below:*

*The Plan acknowledged the Department's findings and stated that the Plan's ongoing or planned corrective actions included the following:*

- The work plan for a complete review of the provider dispute resolution process was included in the Plan's response dated August 30, 2007, and status updates are included in the Plan's monthly reporting to the Department. This comprehensive review will address the Department's findings related to inappropriate dispute resolutions and the related letters. In addition, the Plan's review will address the Department's findings related to the late processing of provider disputes and the inability of customer service to appropriately access dispute information.*
- The Plan will implement focused audit procedures related to the provider dispute resolution process including inappropriate dispute resolutions. The audit will also address the findings of incorrect information requests to the provider and incorrect interpretation of the dispute review by the claims examiners. The Plan's weekly self-audits of the provider dispute resolution process are performed based upon a random sample of fifty closed PDR cases. They are evaluated against the Plan's standard claims processing policies and procedures to determine whether the dispute was resolved appropriately.*

*The Plan's self-audits are evaluated against the Determination Accuracy (DA) measurement. This performance measure is defined as the "percent of disputes resolved appropriately." The Plan's success standard for the DA measurement is 97.00%. Therefore, if the Plan achieves a success rate of 97.00% or higher for the cumulative audit results for the period December 1, 2007 to March 31, 2008, the Plan will no longer deem it necessary for the focused audits to continue. However, the proper determination of provider disputes will continue to be included in the Plan's standard monthly quality audits. The self-audit will be conducted by internal staff dedicated to quality oversight of operations. This team is independent of the PDR team and reports to a different management team within UnitedHealthcare. The Plan believes it is appropriate to engage this team for this purpose, as it represents a separation of duties and management that will assure the objectivity of the self-auditing process. The Plan's Vice President of Transactions Oversight will review the results on a monthly basis. The results will be included in the monthly reporting to the Department by February 1, 2008.*

*By January 1, 2008, the Plan stated that it will establish a dedicated rework team in Letterkenny, Ireland to adjudicate the dispute resolutions determined by the Cypress, California provider dispute research team. This dedicated team will help ensure consistent communication between the Cypress, California PDR researcher and the claims examiner to facilitate appropriate determinations. By February 1, 2008, the Plan stated that it will implement new processes to appropriately identify first time claim submissions so that they can be appropriately excluded from the Plan's PDR reporting.*

**The Department finds that the Plan's compliance efforts are not fully responsive to the deficiencies cited and the corrective actions required. The Plan is required to submit the policy and procedure that will be used by the new rework team in Letterkenny with its response to this Final Report. In addition, the Plan needs to identify the management position responsible for overseeing the work of the new rework team and provide a description of the monitoring system implemented to ensure ongoing compliance by the team. Finally, the Plan is required to continue its monitoring process for a sufficient length of time (i.e. additional six months) after compliance levels are achieved to demonstrate ongoing compliance.**

### C. ADMINISTRATIVE CAPACITY

Section 1367 (g) and Rule 1300.67.3 require that health care service plans maintain "the organizational and administrative capacity to provide services to subscribers and enrollees" and that a plan's organization, administrative services, and policies must "result in the effective conduct of the plan's business" and "provide effective controls."

Our preliminary examination findings (reported in the Department's July 17, 2007 Preliminary Interim Report) found that the Plan had not demonstrated that it has maintained the organizational and administrative capacity to provide services to subscribers and enrollees as follows:

1. The Plan had not demonstrated "effective controls" to oversee the claims processing functions<sup>3</sup> that it delegated to the following affiliated<sup>4</sup> and non-affiliated entities:

Entity/Location	Contracting Party	Date Implemented	Claim Functions
Lason Systems, Inc. /Utah	PHS	May 2006	Front end – Scanning and maintenance of scanned records.
PacifiCare International Limited (PIL) /Ireland	Plan	1999	Claim Processing – Adjudication for NICE (HMO & In-network POS) including: <ul style="list-style-type: none"><li>• HMO stop loss claims</li><li>• HMO chemo &amp; injectible claims</li><li>• HMO rework claims</li></ul>
PSO (TX) PSO merged with PHPA. PSO is sometimes used in reference to the Texas location for	PHPA	May 2006	Claims Processing and Customer Service <ul style="list-style-type: none"><li>• HMO transplant claim processing</li><li>• HMO Recovery</li></ul>

<sup>3</sup> This information was provided in this requested format to the DMHC examiners on June 26, 2007.

<sup>4</sup> PHS is PacifiCare Health Systems, LLC (Grandparent company). PHPA is PacifiCare Health Plan Administrators (Parent company)

Entity/Location	Contracting Party	Date Implemented	Claim Functions
PHPA.			• POS Out-of-Network
MedPlans Partners, Inc	PHS	May 2006	Claims Processing for POS Out-of-Network

All of the substantial deficiencies disclosed during the early stages of our examination and described in this report show that the Plan's processes are insufficient to provide effective controls over the claim operations.

The Plan provided information regarding the oversight and monitoring it performs over these delegated processes but the Department found that this was not sufficient given all the claim processing problems disclosed in this examination.

2. The Plan had not demonstrated that it had sufficient staffing and resources to manage its claims inventory. The Plan stated that the backlog in the Plan's Point-of-Service claims inventory grew because staff and resources were redirected to address contract loading problems affecting their PPO (preferred provider organization) line of business under the PacifiCare Life Insurance Company (Department of Insurance licensee). This demonstrated the Plan's failure to address compliance problems as needed because of its inability to allocate resources and staffing to ensure compliance with the claim settlement requirements.
3. The Plan failed to demonstrate that it can readily provide accurate contracts and contract information in order for the Department to review the payment accuracy of claims selected for our review. Thirteen (13) out of twenty-five (25) contracts or fee schedules were not provided timely and four (4) of these contracts could not be provided for the "RIMS-B Paid Sample" of claims selected for review for payment accuracy.

In addition, it was brought to the Department's attention through numerous complaints from providers that the Plan had failed to properly "load" provider contracts causing claims to be incorrectly paid. At the start of the examination, the Plan informed the Department that this problem did not affect lines of business under PacifiCare of California. However, later in the examination this assertion was retracted and the Plan informed the Department that this problem did impact the PPO network which is utilized in the Plan's Point-of Service product Tier 2 option.

4. The Plan failed to demonstrate that it maintained adequate control over documents needed to process claims and provider disputes. These documents and other correspondence were delayed in queues and were not processed timely. These delays negatively impacted the Plan's ability to pay its claims correctly and to meet claims processing turnaround time requirements. The correspondence in connection with claims and provider disputes such as medical records and letters of agreement were not reviewed timely and were held in queues within the correspondence tracking system called "Document DNA."

It is apparent that under the current organizational structure, it is impossible for the Plan to demonstrate that it is able to exercise independent control over its operations, provide adequate oversight of delegated functions, and to have adequate resources (including staffing) to properly perform its claim processing functions to ensure compliance with the Knox-Keene Act and Regulations.

The Plan was required to file an undertaking that all executive management (i.e., CEO, CFO, COO and Medical Director) and key staff (i.e., Director of Regulatory Compliance, Claims, Information Technology and clinical staff) are to be employed by the Plan and located at the Plan's administrative offices in California, unless the Plan can show to the satisfaction of the Department through a Corrective Action Plan (CAP), that adequate oversight, authority and responsibility are retained by the Plan. If the CAP is not fully completed at the time the Plan files its response, the Plan was to submit the reason and timeframe that the remaining corrective actions will be submitted to the Department.

The Plan was required to file an undertaking that the processing of POS claims will be returned from Texas to California by July 16, 2007, and performed by Plan employees.

The Plan was required to file an undertaking that it will employ sufficient staff in California to correct the deficiencies cited in this report, as well as other deficiencies found by the Plan, and to ensure that the Plan maintains compliance with the Knox-Keene Act and Title 28 Regulations at all times.

The Plan was required to file an undertaking that reflected a commitment by its Ultimate Parent Company that the Plan shall have all resources needed (including staffing, information technology systems and funding) to correct the deficiencies cited in this report and to ensure compliance with the Knox-Keene Act and Title 28 Regulations at all times.

As part of the CAP, the Plan will need to file revised administrative services agreements that it has with PHPA, its affiliated or non-affiliated entities to reflect changes in its operations and appropriate access to all, staffing, resources including information technology resources as needed to result in effective compliance with the Knox-Keene Act and Regulations.

The revised agreement(s) were to be filed electronically as amendment filings with the Department.

**The Plan's August 30, 2007 response is summarized below:**

*The Plan stated that it is committed to correcting the deficiencies cited in this report, and to having sufficient staff to maintain and monitor compliance with the Corrective Action Plans submitted with the response and being developed for inclusion in monthly reporting to the Department. The Plan's corrective actions include:*

- *Creation of a Vice President of Transactions Oversight position for the Cypress, CA location. In its November 2007 monthly status report to the Department, the Plan reported that a Vice President was hired.*

- *Addition of 24 employees for POS claims processing and data entry, 21 in Cypress, California, and three in San Antonio, Texas.*
- *Addition of ten positions to perform functions related to provider dispute resolution.*
- *Addition of three positions to perform functions related to resolution of member and provider claims issues.*
- *Execution of Undertakings related to administrative capacity. These Undertakings were submitted with the Plan's response.*

*Vendor Oversight will include the following:*

*Lason Systems, Inc.*

*Lason scans all original documents, keying claims for batch processing into NICE. The following corrective actions have been implemented:*

- *On February 19, 2007, the Plan implemented a reporting process that compares Cypress mail room envelopes received to quantities received by Lason. The Program Manager responsible for oversight of the Lason vendor arrangement reviews these daily reports.*
- *The policy related to mail intake and routing will be reviewed and updated by October 1, 2007.*
- *The policy related to DOC DNA correspondence routing will be reviewed and updated by November 30, 2007,*

*PacifiCare International Limited*

*The Plan acknowledged that the transition of its POS claims to Ireland (PacifiCare International Limited (PIL)) was not effective. The Plan confirmed that all POS claims processing, both in and out of network, will be completed in Cypress, California.*

*The Plan stated that it is not aware of any other Department findings that relate to the use of PIL. The Plan initiated its contractual arrangements with PIL in 1999 to increase its claims processing capabilities.*

*PacifiCare Health Plan Administrators, Inc. – PSO TX*

*The Plan confirmed that all POS claims processing, both in and out of network, will be completed in Cypress, CA. The Plan will review other functions performed for the Plan by PHPA – PSO TX and determine if additional controls and/or oversight are necessary to assure the Plan's compliant operations.*

*MedPlans Partners, Inc.*

*The Plan also stated that by November 1, 2007, the Plan will no longer use MedPlan Partners, Inc. to process POS out-of-network claims; these claims will have been transitioned to Cypress, CA based staff.*

### Contract Documentation

*The Plan agrees 13 contracts were not provided to the Department in a timely manner. The Plan reminded the Department that the personnel accountable for contract storage moved offices the day of the request. The delay in contract production was impacted by the time required to reconnect computers to networks.*

*The Plan agreed that 3 contracts were never provided to the Department. The Plan has asked each of these three providers for a copy.*

### PPO Contract Loading Timeliness and POS Claims Payment Accuracy

*The Plan acknowledged that Preferred Provider Organization contracts were negotiated with effective dates that were prior to contract execution and contract load dates, to bridge network gaps for UnitedHealth Group members. The Plan acknowledged that it is possible that POS members could have accessed a newly contracted PPO provider and received services during a time when the contract had not been loaded. However, the Plan is unaware of any Department findings that claims were paid untimely because of delays in contract loading. The Plan stated that it would respond to additional issues identified by the Department in its Preliminary Report.*

### Document Routing

*The Plan stated that its correspondence is routed to 21 different queues related to the Plan's commercial products, based on subject matter. The queues are reviewed on a daily basis to match to claims, update provider demographic information, initiate a member appeal, etc. The following corrective actions have been implemented for correspondence:*

- The 21 correspondence queues have been defined and are maintained separately to ease review and routing.*
- Owners and back up owners for each queue have been identified.*
- Weekly correspondence inventory and aging reports for each queue were written by April 2007.*
- Beginning July 11, 2007, employees assigned to each queue and the Transaction Project Director meet weekly to review progress and inventory levels to monitor inventory levels and ensure appropriate turn around time.*

*The Plan responded that Management Oversight will include the Plan's President, Chief Financial Officer, Vice President of Transactions Oversight and Medical Director.*

*The Plan stated that its President, Chief Financial Officer and Medical Director have been and continue to be located in Cypress, CA in addition to Vice President of Transactions Oversight position, which is newly created to enhance Plan oversight. The Plan has retained adequate oversight, authority and responsibility through the management team listed above as well as other Plan staff.*

*The Plan considers these positions to be employees of the Plan. The salary cost of these positions is included in the Plan's statutory financial statements. The Plan does not consider the payroll tax identification number relevant to the substance of each person's commitment of time and effort to the Plan. This issue has been documented fully with the Department.*

*POS Claims Processing Undertaking*

*The Plan's undertaking related to POS claims processing was included in its response.*

*Sufficient Staffing*

*The Plan's undertaking related to Sufficient Staffing was included in its response.*

*Ultimate Parent Resource Commitment Undertaking*

*The Plan's undertaking related to the Ultimate Parent commitment that the Plan shall have all resources needed (including staffing, information technology systems and funding) to correct deficiencies cited in this report to ensure compliance with the Knox-Keene Act and Title 28 Regulations at all times was included in the Plan's response.*

*The Executive Vice President, UnitedHealth Group, affirmed the Ultimate Parent Company's commitment to PacifiCare to have the resources necessary to comply with the Knox-Keene Act and Title 28 Regulations and the California market at a meeting with Cindy Ehnes and members of the DMHC management staff on July 9, 2007. UnitedHealth Group and the Plan believe that local accountability remains a significant force in the relationship between consumers and their health plans*

*Revised Administrative Services Agreements*

*On June 19, 2007, the Plan submitted an amendment to its Administrative and Solicitor Firm Services Agreement with PHPA pursuant to Undertaking No. 4 of the Plan's Material Modification filing, Transition of Routine Plan Functions, DMHC Reference No. 20060700. The Plan has revised the June 19th Amendment to reflect changes in its operations and appropriate access to staffing and other resources, including information technology resources, as needed to result in effective compliance with the Knox-Keene Act and Regulations (the "Revised Amendment"). The Revised Amendment was eFiled with the Department on August 30, 2007. A copy of the Revised Amendment was included in the Plan's response.*

The following are additional administrative findings not reported in the Preliminary Interim Report but were reported in the Preliminary Report:

- The Plan indicated that it follows contract loading timeframes established in policies of its Parent company. During discussions with the Plan's provider dispute unit and its network management unit, the Plan indicated that "rework" projects containing claims

that require reprocessing due to retroactive contract provisions are generally initiated by network management. However, the Parent company's procedures do not specifically state the process for routinely identifying those claims that fall within the retro contract period and for reprocessing the impacted claims.

- The Plan acknowledged that comments documenting the loading of a contract into the contract information system are "overridden" whenever a change is made. This results in a lack of an audit trail to document the dates when new or revised contract provisions are loaded into the system.
- While the Plan acknowledged that Preferred Provider Organization contracts were negotiated with effective dates prior to contract execution and contract load dates, to bridge network gaps for UnitedHealth Group members, the Plan stated in its August 30, 2007 response that it was unaware of any Department findings indicating that claims were paid untimely due to delays in the contract loading. Subsequent to this date, the Department brought to the Plan's attention rework project #58048 which documented that a United "gap" contract was signed on June 26, 2006 but was not loaded into the Plan's contract database until October 6, 2006. The project contained claims with dates of service that were within the effective dates of the contract but due to the delay in loading the contract, the correct payment of the claims were delayed. Additionally, the Department requested the Plan to review thirty-five (35) contracts that were loaded late to determine if claims were potentially impacted and should be reprocessed. Of that sample, sixteen (16), or 45.7 %, were potentially impacted. However the Plan did not identify these claims to be reprocessed. The following are examples:

Contract No.	Contract Load Days Lapsed after Signed by Provider	Plan Comments
308004	276 days	Rate changed. Potential impact to drug claims, but reprocessing was not initiated.
313667	221 days	Potential claims impacted, but reprocessing was not initiated.
317604	128 days	Potential claims impacted, but reprocessing was not initiated.
326942	534 days	Potential claims impacted, but reprocessing was not initiated.
322194	366 days	Incorrect effective date entered. Potential claims impacted, but reprocessing was not initiated.

**All of the above issues were referred to the Office of Enforcement for administrative action.**

The Plan was required to submit a revised CAP that includes revisions to its operations and policies and procedures that will include, but are not limited, to correction of the deficiencies

noted above. The policies and procedures were to include procedures that reflect that the Plan is routinely monitoring retroactive contract activity, as well as, procedures to review and identify all affected claims including those that have been submitted as provider disputes or projects requiring reprocessing as a result of the retroactive contract provisions. The policies and procedures were also to reflect routine procedures to identify and review all contracts loaded late or outside of the established timeframes indicated by the contract loading guidelines. The CAP was to state the types of reports that will be maintained by the Plan to document the loading of the contracts and the Plan's oversight of this process.

In addition the Plan was required to review all provider contracts in the NICE and RIMS claims systems with retroactive effective dates or late load dates for the period January 1, 2006 through the date of the Plan's response to this report. The Plan was required to identify all potential claims that were impacted by the retroactive contract provisions. The Plan was required to submit a spreadsheet of all claims requiring remediation as a result of the retroactive contract provisions. The spreadsheet was to include the following fields:

- Contract number
- Provider name
- Signature dates
- Contract load dates
- Reprocessed claims by claim number
- Date original claim received
- Date original claim paid
- Additional information received, if applicable
- Additional payment amount made
- Date additional payment made
- Interest and penalties paid
- Check number for additional payment made

If the Plan was unable to complete remediation by the due date of the response to the Preliminary Report, the Plan was required to submit a timeline that is no longer than one year from the due date which reflects progress and completion of the remediation. In addition, the Plan shall submit monthly status reports to the Department until the remediation is completed.

**The Plan's November 14, 2007 response is summarized below:**

*The Plan acknowledged the Department's findings. The Plan stated that by January 1, 2008, the Plan will implement a revised process and related Policy and procedure document to automatically refer, on a regular basis, all retro active contract loads to the claim project review team to review and remediate impacted claims.*

*The Plan stated it will identify all potential claims that were impacted by a retroactive effective contract during the period January 1, 2006 through November 14, 2007 to determine that the*

*correct contract rate was used. The Plan is in the process of performing a quality review of the report detailing the providers to be reviewed for possible remediation to ensure its accuracy. The Plan estimates completion of the quality review by December 14, 2007. After the quality review is complete, the Plan will determine the remediation timing and will provide updates to that work plan in the monthly reporting to the Department.*

**The Department acknowledges that the Plan was to implement a revised process and related policy and procedure document by January 1, 2008. The Plan needs to provide a description of the revised process and a copy of the related policy and procedure document with its response to this Final Report. In addition, these revised policy and procedure document should address the loading of a contract so that there is an audit trail of the date(s) when new or revised contract provisions are loaded into the system.**

**The Department acknowledges that the Plan anticipates that its remediation efforts will be completed by August 2008 as reported in its November 2007 status report. In addition, the Department acknowledges that 95% compliance may not be achieved by the Plan until remediation is complete because of the remediation's impact on the compliance percentage. However, the Plan is required to submit evidence of its remediation efforts on a monthly basis. These monthly status reports are due within 15 days following the close of each month. The first status report will be due on February 15, 2008, listing individually by claim all interest and penalties paid up to January 31, 2008. The status report should be submitted through the Department's eFiling web portal, as described in the cover letter, until the remediation is fully completed. Large remediation files can be submitted directly to the Department on a CD with an E-1 filing submitted through the web portal stating that the remediation file was submitted directly to the Department on a CD.**

## **SECTION II. NON-ROUTINE EXAMINATION**

The Plan is advised that the Department may conduct a non-routine examination, in accordance with Rule 1300.82.1, to verify representations made to the Department by the Plan in response to this report. The cost of such examination will be charged to the Plan in accordance with Section 1382 (b).

**No response was required for this section.**



---

**From:** Kerk, Phyllis B  
**Sent:** Monday, February 25, 2008 05:55 PM  
**To:** Jackson, Shuntel M; Knous, Jane S  
**CC:** Berkel, Susan L; De La Torre, Rebeca E; Diaz, Jean; Hays San Filippo, Elizabeth L  
**Subject:** RE: PacifiCare: New Day Claim Acknowledgement Clarified

That's good to have in writing since it has been our understanding since the beginning, the way ICE trained on it and how we audit the delegated providers.

Phyllis Kerk

Director, Provider Audit

-----Original Message-----

From: Jackson, Shuntel M

Sent: Monday, February 25, 2008 3:52 PM

To: Knous, Jane S; Kerk, Phyllis B

Cc: Berkel, Susan L; De La Torre, Rebeca E; Diaz, Jean; Hays San Filippo, Elizabeth L

Subject: FW: PacifiCare: New Day Claim Acknowledgement Clarified

Hello. I received clarification from the DMHC (Susan Miller) regarding the issuance of acknowledgement letters for new day claims. See email below. I will be scheduling a quick meeting tomorrow to discuss internally.

Shuntel Jackson

Regulatory Affairs - West Region

-----Original Message-----

From: Miller, Susan [mailto:SMiller@dmhc.ca.gov]

Sent: Saturday, February 23, 2008 11:08 AM

To: Jackson, Shuntel M

Subject: RE: PacifiCare: New Day Claim Acknowledgement

Hi,

There is no requirement to proactively send out acknowledgment letters to providers upon receipt of a new claim for services rendered. The payor must be able to recognize that they have received a claim, within the timeframe, should a provider call to confirm the Plan's receipt of a claim.

Thanks,

sjm

Susan J. Miller

Examiner

Department of Managed Health Care

-----Original Message-----

From: Jackson, Shuntel M [mailto:Shuntel.Jackson@phs.com]

Sent: Fri 2/22/2008 4:30 PM

To: Miller, Susan

Subject: PacifiCare: New Day Claim Acknowledgement

Hi Susan,

As a follow up to our conversation on 2/21/08, please confirm that the following language does not require the plan or plan designated payor send written acknowledgement letters for new day claims. Per our conversation, the language is requiring that the plan or designated payor be acknowledgement "ready" meaning we need to be able to locate a claim and verify receipt should a provider call to inquire on claim status.

1300.71(c) Acknowledgement of Claims. The plan and the plan's capitated provider shall identify and acknowledge the receipt of each claim, whether or not complete, and disclose the recorded date of receipt as defined by section 1300.71(a)(6) in the same manner as the claim was submitted or provide an electronic means, by phone, website, or another mutually agreeable accessible method of notification, by which the provider may readily confirm the plan's or the plan's capitated provider's receipt of the claim and the recorded date of receipt as defined by 1300.71(a)(6) as follows:

(1) In the case of an electronic claim, identification and acknowledgement shall be provided within two (2) working days of the date of receipt of the claim by the office designated to receive the claim, or

(2) In the case of a paper claim, identification and acknowledgement shall be provided within fifteen (15) working days of the date of receipt of the claim by the office designated to receive the claim.

(A) If a claimant submits a claim to a plan or a plan's capitated provider using a claims clearinghouse, the plan's or the plan's capitated provider's identification and acknowledgement to the clearinghouse within the timeframes set forth in subparagraphs (1) or (2), above, whichever is applicable, shall constitute compliance with this section.

Shuntel Jackson  
Regulatory Affairs - West Region  
PacifiCare, A United Healthcare Company  
Tel: 714-226-3891  
shuntel.jackson@phs.com

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REGULATORY AFFAIRS  
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FEB 28 2008

Arnold Schwarzenegger, Governor  
State of California  
Business, Transportation and Housing Agency

Department of Managed Health Care  
980 Ninth Street, Suite 500  
Sacramento, CA 95814-2725  
(916) 323-0435 -Phone  
(916) 323-0438 -Fax  
enforcement@dmhc.ca.gov

February 26, 2008

**SENT VIA U.S. MAIL**

Nancy Monk  
Vice Pres., Govt./ Regulatory Affairs  
PacifiCare of California  
5995 Plaza Drive MS CA112-0267  
Cypress, California 90630

**RE: Claims Payment, Provider Dispute Mechanisms, and Administrative Capacity  
Enforcement Matter Numbers 06-185 and 07-356**

**LETTER OF AGREEMENT**

Dear Ms. Monk:

The Department of Managed Health Care's (DMHC) Office of Enforcement recently received a referral from its Division of Financial Oversight (DFO) related to a recent financial survey conducted at PacifiCare of California (PacifiCare). (This referral is designated as Enforcement Matter Number 07-356.) On June 4, 2007, the DFO commenced a non-routine examination and found various violations of both the Knox-Keene Health Care Service Plan Act of 1975, as amended, (KKA), and the undertakings agreed to by PacifiCare, signed after its acquisition by UnitedHealth Group Incorporated ("UnitedHealth Group"). Those violations, and the findings of the exam, are noted below.

The purpose of the non-routine financial examination was to verify corrective actions made by PacifiCare in response to a previous examination memorialized in a Final Report dated December 29, 2005. The recent examination also reviewed PacifiCare's claims processing operations due to the self-disclosure of deficiencies during a site visit on February 7, 2007, as well as to confirm corrective actions taken as a result of this site visit. Also, the DMHC had received, as far back as the year 2006, numerous complaints from providers regarding PacifiCare's claims settlement practices and Provider Dispute Resolution (PDR) system. (These complaints are consolidated in Enforcement Matter Number 06-185, and handled jointly herein.)

Matter ID: 07-356  
Doc. No.: 26423

It should be noted that at all times referenced herein PacifiCare worked collaboratively with the DMHC to resolve all issues that were identified. Moreover, PacifiCare advised the DMHC on numerous occasions that it was committed to correcting the deficiencies that were found, as well as maintaining adequate staffing for administrative capacity to effectively perform PacifiCare's duties on behalf of all of its enrollees and its health care providers. In this regard, below is a summary of the noted violations as well as the examination's findings:

### **CLAIMS SETTLEMENT PRACTICES - UNJUST PAYMENT PATTERN**

As part of its review procedures, the DFO reviewed a total of 100 denied claims, randomly selected from the claims system that PacifiCare uses to process its point-of-service (POS) claims called "RIMS." Of that sample, 39, or 39%, were denied incorrectly. The DFO also reviewed claims from PacifiCare's claims system called "NICE." After PacifiCare initially provided the DFO with an incomplete sample of claims to review, PacifiCare provided a new data extract of 50 NICE claims. Of those 50 claims, 15, or 30%, were denied incorrectly as the IPA/Medical Group responsibility, when they were actually PacifiCare's responsibility. Also of note, the DFO's analysis of PacifiCare's POS claims denied from January 1, 2006, through June 14, 2007, noted a total of 40,784 denied claims, of which 22,707, or 55.7%, were denied as duplicate claim submissions, resulting in reprocessing errors and a remediation effort after several providers received letters stating that they had submitted duplicate claims, when they had not.

Section 1300.71, subdivision (a)(8)(F) of Title 28 of the California Code of Regulations (CCR), pursuant to Health and Safety Code section 1371, specifies that a demonstrable and unjust payment pattern/unfair payment pattern may be found when a plan fails to provide providers with an accurate and clearly-written explanation of the specific reasons for denying, adjusting, or contesting a claim at least 95% of the time for affected claims. Based on the above information, PacifiCare was in violation of this regulation.

In addition, the DFO's review included 25 late paid claims from the NICE system. In four of those claims, or 16%, PacifiCare did not pay interest correctly on the late payment, as required by Health and Safety Code section 1371 and 1371.35. Moreover, the DFO reviewed 25 late paid claims from the RIMS system, and out of these, 17 had substantial delays because claims information failed to be manually re-keyed into RIMS after initially processed in NICE.

Section 1300.71, subdivision (a)(8)(K) of Title 28 of the CCR, pursuant to Health and Safety Code section 1371, provides that a demonstrable and unjust payment pattern/unfair payment pattern may be found when a plan fails to reimburse at least 95% of complete claims with the correct payment, including the automatic payment of all interest and penalties due and owing. Based on the above information, PacifiCare was in violation of this regulation as well.

PacifiCare agrees with the DMHC that compliance with prompt payment statutes and regulations are important, and has added 24 employees to work on its POS claims processing and data entry,

centralizing this function in its Cypress, California location. In addition, PacifiCare has added six (6) additional staff to research the root cause of the inappropriate denials based on incorrect determination of financial responsibility that were found in NICE. For these claims, PacifiCare believes that the out-of-area determination programming was inaccurate and that such denials should not recur for this reason. PacifiCare has also agreed to re-train claims processing staff on accurate interest rates for late payments, as well as the appropriate application of the statutory penalty.

### **PROVIDER DISPUTE RESOLUTION MECHANISM**

Another part of the DFO's review included PacifiCare's PDR mechanisms. The DFO found that PacifiCare failed to process provider disputes accurately pursuant to section 1300.71.38 of Title 28 of the CCR. This regulation requires PacifiCare, and its capitated providers that pay claims, to establish a fast, fair, and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes while complying with various other provisions of the KKA, and their applicable regulations.

The DFO reviewed the PDR claims under the standard set forth by the above-referenced regulation. PacifiCare had 45 working days after receipt of the dispute to issue a written determination, stating all of the pertinent facts, and explaining the reasons for its determination. (See Cal. Code Regs., tit. 28, §1300.71.38, subd. (f).) Of 49 overturned provider disputes that were reviewed, 14, or 29%, were resolved incorrectly. Similarly, 14 of the 49, or 29%, were processed outside of the 45-day regulatory standard. Moreover, 11, or 22% of the 49, had letters sent to the providers requesting information that was not needed to process the claim, or some of those letters requested the wrong information. In addition, six, or 30%, of 20 upheld provider disputes that were reviewed had incorrect or inaccurate determination letters, and it was found that this occurred because there was no process for ensuring that results of the review documented in PacifiCare's "REVA" system were interpreted correctly by those responsible for finalizing the claim and issuing the PDR determination.

Further, when a provider would call PacifiCare regarding a PDR claim, PacifiCare lacked an effective system to respond to the call, often instructing the provider to submit another dispute. Finally, during the DFO's review, it was determined that PacifiCare's PDR tracking system, REVA, included "projects," such as first-time claims submissions. Further, PacifiCare was unable to distinguish between these first-time claims and actual provider disputes, impacting the DFO's statistics and complicating an accurate reporting, as required by the KKA. (See Cal. Code Regs., tit. 28, §1300.71.38, subd. (k).) Based on such information, PacifiCare was in violation of all of the above-referenced regulations.

The DMHC believes that adequate provider dispute mechanisms are part and parcel of ensuring a viable and robust marketplace, and the DMHC is committed to ensuring the continued role of the professional as the determiner of the patient's health needs, fostering the traditional relationship of

trust and confidence between patients and their doctors. (Health & Saf. Code §1342, subd. (a).) Moreover, the DMHC is dedicated to promoting among all health care service plans a transparent and fully functioning PDR system, which should further ensure that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management. (Health & Saf. Code §1367, subd. (g).)

In response to this enforcement action, PacifiCare confirms that it too shares the DMHC's commitment to a transparent and fully compliant PDR system. In this regard, PacifiCare hired 18 additional employees to perform functions related to PDR and provider claims issue resolution. In addition, PacifiCare acknowledged that its PDR tracking system, REVA, required certain enhancements to function more efficiently and effectively, and PacifiCare has committed to making those technological enhancements to ensure smoother PDR.

#### **ADMINISTRATIVE CAPACITY**

After PacifiCare was acquired by UnitedHealth Group, both PacifiCare and UnitedHealth Group agreed in an undertaking to maintain PacifiCare's organizational and administrative capacity. This undertaking was critical, in that representations were made to the DMHC that resources would be consolidated to create greater efficiency. Those consolidated resources were to include sufficient number of staff employed, including those with decision-making authority to provide immediate resolution to potential problem areas. However, throughout the DFO's recent exam, it was evident that PacifiCare failed to demonstrate adequate staffing for effective administrative capacity. DFO found that PacifiCare failed to properly oversee both claims processing functions and PDRs, as required by Health and Safety Code section 1367, subdivision (g), and section 1300.67.3, subdivision (a)(2) of Title 28 of the CCR. This determination was also based on significant numbers of incorrectly denied claims, incorrectly processed and incorrectly determined provider disputes, and routine underpayment of interest/penalties on late paid claims.

In addition, PacifiCare delegated certain claims payment functions to affiliated and non-affiliated entities, which were responsible for processing more than 50% of PacifiCare's claims. Entities such as Lason Systems, Inc. in Utah; PacifiCare International Limited, in Ireland; PSO, in Texas; PacifiCare Health Plan Administrators, and MedPlans Partners, Inc., all carried certain claims payment responsibilities without sufficient oversight by PacifiCare to effectively conduct the plan's business. For instance, the DFO found that PacifiCare did not provide sufficient oversight over Lason because out-of-network claims in the POS product required manual input by Lason into RIMS after a transition from NICE. PacifiCare failed to effectively oversee this process, resulting in late payment on numerous claims.

Also evidencing a lack of administrative capacity issues, PacifiCare failed to demonstrate to the DFO that it had sufficient staffing and resources to manage its total claims inventory. Further, PacifiCare did not readily provide to the DFO accurate contracts or contract information in order for the DFO to review accuracy of payments. The ready accessibility of contracts is required

pursuant to Health and Safety Code sections 1346, subdivision (a), 1381, and 1382, subdivision (a). Despite this, 13 out of 25 contracts or fee schedules were not provided to surveyors in a timely manner and four of these contracts could not be provided for the RIMS Paid Sample of claims selected for review. PacifiCare maintains that at the time the DMHC's requests for contract information were made, the office responsible for maintaining the contracts was in the process of moving, and those files had already been packed for the move.

With respect to PacifiCare's PDR mechanisms, PacifiCare failed to demonstrate to surveyors that it maintained adequate controls over documents needed to process claims and provider disputes. Documents and other correspondence, such as medical records and letters of agreements with providers, were found held-up in queues on a computer system called Document DNA; none were processed timely. These delays negatively impacted PacifiCare's ability to pay its claims correctly, as well as meet claims processing turnaround times.

All of the above evidenced extensive administrative capacity issues implicating the undertaking referenced above, as well as the KKA and its promulgated regulations. The DMHC believes that administrative capacity is fundamental to ensuring that health care service plans run efficiently and effectively to promote the delivery and the quality of health and medical care to the people of the State of California who enroll in these plans. (Health & Saf. Code §1342.)

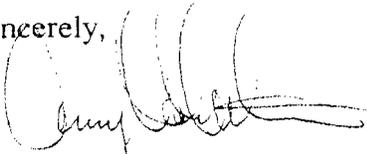
Faced with these deficiencies, PacifiCare advised the DMHC that its ultimate parent, UnitedHealth Group, is committed to providing PacifiCare with all of the resources it needs (staffing, information technology, and funding) to correct all of the deficiencies found by the DMHC. Moreover, PacifiCare concurs that additional oversight of delegated claims processing functions to affiliated and non-affiliated entities is appropriate to ensure compliance with the KKA. Consequently, PacifiCare created a Vice President of Transactions Oversight position to monitor compliance of these delegated functions, as well as all of the other functions retained in PacifiCare's Cypress, California location. In addition, PacifiCare hired 48 additional staff to perform POS claims processing, PDR, and functions related to member and provider claims issue resolution. PacifiCare believes the additional staff, as well as centralizing the POS claims processing functions in Cypress will enhance its administrative capacity. And as for PacifiCare's Document DNA systems, PacifiCare maintains that its total document management inventory, as well as its aged inventory, now shows marked improvement and better turnaround times for timely processing of claims and provider disputes.

Thus, in consideration of all of the above, the DMHC has assessed an administrative penalty against PacifiCare in the amount of \$2,000,000.00. This penalty was assessed pursuant to Health and Safety Code section 1386, subdivision (b)(6). In addition, the DMHC is requiring PacifiCare to engage the services of a monitor to oversee its claims, PDR, and administrative capacity issues for a period sufficient to ensure that PacifiCare is complying with its obligations under both the KKA and the undertakings referenced above.

Ms. Nancy Monk  
Letter of Agreement  
Page 6

In collaborating with the DMHC toward a quick resolution of this matter, as well as promoting timely implementation of all of the corrective actions promised, PacifiCare has agreed to pay this penalty. PacifiCare has also agreed to engage the services of the monitor, as noted above, within 30 days of signing this Letter of Agreement. Such monitor will be reporting all findings to the DMHC on a regular basis, and as further delineated in the Scope of Work to be provided by the DFO. Finally, PacifiCare understands that the DMHC's Office of Enforcement will maintain jurisdiction over this entire matter until such monitor confirms that PacifiCare's corrective actions were in fact implemented, are adequate, and are effective to resolve the issues identified.

Sincerely,



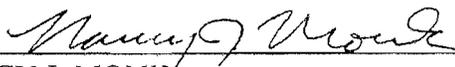
Amy L. Dobberteen  
Assistant Deputy Director  
Office of Enforcement

AAA:mrr

cc: Naomi Yoshihara, Accounting Officer- Department of Managed Health Care

**ACCEPTED BY PACIFICARE OF CALIFORNIA:**

Dated: February 28, 2008

  
\_\_\_\_\_  
NANCY J. MONK  
Vice President, Govt. Relations/ Regulatory Affairs  
PacifiCare of California