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BEFORE THE INSURANCE COMMISSIONER

OF THE STATE OF CALIFORNIA

In the Matter of PACIFICARE LIFE AND HEALTH INSURANCE COMPANY, Respondent.	File No. UPA 2007-0004 OAH No. 2009061395 **EXPERT REPORT OF RICK McNABB**

optimity ADVISORS

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Rick McNabb Expert Report

R. McNABB EXPERT REPORT

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I. Qualifications.

I am currently the Managing Partner for Optimity Advisors, a consulting firm that specializes in developing solutions for a variety of industries with respect to operational issues, and, in particular, those issues impacting information technology ("IT"). I have specialized in the healthcare and insurance industries since 1987 and in the IT area since 1979. My focus in the IT area has been on software (and to a lesser extent hardware) implementations, integration of data and operations, and I have led or been actively involved in some of the largest healthcare integrations and IT transformations in the United States. For example, I led:

- the total IT rebuild of the Federal Employees Program healthcare operations (program covering 54% of total federal workforce adjudicating approximately 600,000 claims per day);
- consolidation of Cigna Healthcare's twenty-two separate claims platforms into two; and
- IT due diligence efforts for the Prudential HealthCare/Aetna and USHealthcare/Aetna mergers.

I reference these large, complex transactions, because the overall approach and techniques used to successfully complete such projects differ from those that might be applied in an integration project that is magnitudes smaller. I also have led projects to develop and implement new claims platforms, web portals, eligibility systems, medical management, membership and financial reporting systems, call centers and insurance products for numerous health plans throughout the United States. A copy of my Curriculum Vitae is attached (Attachment A).

II. Summary Of Conclusions.

The combination of PacifiCare and UnitedHealthGroup ("United") was the third-largest health plan merger in history. As I would expect from a company experienced in health plan integrations like United, the management structure and processes used to integrate these two companies followed classic project management standards, which were tailored appropriately to the size and complexity of the project. United and PacifiCare management, moreover, made well reasoned decisions with regard to the integration process and the transition from manual to automated processes for the PacifiCare pre-merger ("legacy") business.

Like all significant healthcare integrations, the PacifiCare/United integration experienced some challenges and problems. That such challenges and problems arose, however, does not show that the integration was flawed. Rather, how the company responded to these challenges and problems showed that the process was well managed. The effectiveness of this management is borne out, for example, by PacifiCare/United's claim payment timeliness metrics during the Market Conduct Examination period (June 23, 2006 to May 31, 2007), which compared favorably with both industry benchmarks and the reported performance of several major health plans. The criticisms being pointed now at the PacifiCare/United integration are after-the-fact, second-guessing of good faith, well-reasoned business decisions. Further, CDI expert witness Ronald Boeving has wholly failed to draw any actual connection between those criticisms and the alleged violations he seems to be referencing.

III. PacifiCare/United Was A Successful Merger That Benefited All Stakeholders.

Many healthcare companies have utilized mergers to achieve market expansion, product expansion, marketing and cross-selling opportunities, and to gain efficiencies through operational economies of scale and technology improvements. Achieving these goals not only benefits the combined companies, but key stakeholders as well.

The PacifiCare/United merger is a good example of combining two complementary companies. The merger provided PacifiCare with the size, scale, capital, technology, nationwide market presence, expanded provider network access, improved procedures, processes and quality initiatives the company acknowledged it needed pre-merger. United had invested approximately $2.5 billion in technology in the several years preceding the merger, and subsequent to the merger, PacifiCare was able to take advantage of many of those investments. The merger's success was apparent very early. In fact, when the merger closed, Fitch Ratings raised its ratings on PacifiCare because the "acquisition by (UnitedHealth) has significantly improved PacifiCare's financial position and will enhance its operating profile."

Likewise, at the same time, PacifiCare brought to United multiple benefits, including access to a robust California provider network, the building-blocks for a fully-insured PPO business in California, a well-established HMO product, PacifiCare's Secured Horizons senior insurance products, and well-developed clinical and medical management programs aimed at improving quality of care and better managing medical costs. United also gained PacifiCare's growing pharmacy benefit management business, which then served 5.5 million members.

IV. Synergies Are An Expected Goal And Their Realization Is A Hallmark Of Successful Mergers.

Synergies are the interaction or cooperation of two or more organizations to produce a combined effect greater than the sum of their separate effects. Synergies can be both financial and non-financial. As to PacifiCare/United, much of their estimated and realized synergies were not based upon staff reductions or other cost-cutting measures. Rather, the vast majority of the synergies were realized through the combined companies' market and product expansion, cross-selling, economies of scale and technology improvements.

In my experience, most significant healthcare mergers involving publicly traded companies include public disclosure of estimated synergies. PacifiCare/United's pre-merger projected synergies of $120m to $180m ($70-100m for operating efficiencies) in 2006 were not particularly aggressive compared to estimates from other major healthcare mergers:

Merger	Year	Value	Estimated Synergies
Aetna / US Healthcare	1996	$8.9B	$300m within first 18 months
Aetna / Prudential	1999	$1.0B	$130m to $150m within two-plus years
Anthem / Trigon	2002	$4.0B	$40m (2003), $75m (2004)
Anthem / WellPoint	2004	$16.4B	$150m in 2005, $250m per year thereafter
Coventry / First Health	2005	$1.7B	$20-$30m (2005), $40-60m (2006), $100m (2007)
WellPoint / WellChoice	2005	$6.6B	$25m in 2006; $125m yearly thereafter
PacifiCare / United	2005	$7.4B	$120m to $180m (2006)

While the realized synergy benefits increased over initial estimates after the merger closed, the vast majority of synergies derived from significant business opportunities identified and realized post-merger.

With regard to staffing, virtually every merger necessarily implicates organizational changes, including staffing reductions. These are an inevitable and difficult part of that process. Staff reductions, however, did not represent the majority of the estimated synergy savings for PacifiCare/United. Moreover, PacifiCare already had decided to implement a number of the staffing reductions (specifically around mailroom and eligibility) that were ultimately executed upon in 2006. The staffing reductions did not create human resource constraints in any significant way with respect to PPO claims handling.[1] While a total of twenty to thirty PPO claim handlers were laid off in Cypress, an equivalent number of people were hired or assigned to do the work in Texas.[2] In the case of other staff reductions (specifically mailroom and eligibility data entry functions), the company hired outside experts, *i.e.*, outsourced the work. As a result, the PacifiCare California PPO ("PLHIC") operations did not show a material deterioration in performance.

Retention of employees is a challenge in any post-merger environment. From the outset, PacifiCare/United implemented policies to retain employees with historical knowledge, and its process for doing so improved over time.[3] PacifiCare/United's continuing sensitivity to and focus on this issue was quite appropriate. It would be unrealistic to charge the company with responsibility for employees who voluntarily left the company to pursue

[1] While there were periods where certain staff were hired back on a temporary basis with respect to PPO claims handling, this involved staffing to deal with peaks in activity that are fairly typical in claims handling for virtually all health plans. It is customary in the industry to address these needs through overtime, temporary staffing, or some combination of the two.

[2] Following a strategy utilized by PacifiCare pre-merger, PacifiCare/United also continued to transition handling of some volume of its transactions to a claims handling vendor, MedPlans, a practice that is typical in the healthcare industry.

[3] Additionally, PacifiCare/United in-sourced dozens of IT personnel post-merger to retain historical knowledge.

new opportunities or for personal reasons. And it would be pure speculation to suggest, in hindsight, that PacifiCare could or should have done anything differently in this area.

V. PacifiCare/United Applied A Reasoned, Organized And Appropriate Approach To Integration.

PacifiCare/United's integration plans and processes followed a classic model of program/project management. This classic model is based on commonly recognized standards for program/project management set forth in the Project Management Institute's (PMI) Program Management Body of Knowledge (PMBOK). PMI is a widely-recognized, international organization that provides guidelines and rules for program/project management. PacifiCare/United utilized many of these guidelines in its integration process (*see* Attachment B).

With respect to management and oversight of the integration, PacifiCare/United utilized an experienced team of more than fifty senior employees, including executive vice presidents, vice presidents, directors and other management personnel to oversee and manage the integration process. As part of this process, PacifiCare/United utilized an effective process for decision making, which involved a PacifiCare business lead, a United business lead and an integration team member to share integration responsibilities for specific functional areas. Known as "3 in the Box," Steve Black, the Program Management Office Lead, explained the structure as follows:

> [PacifiCare] and [United] business leads are ultimately accountable for decision making and implementation. The integration team member will guide the process, leverage re-usable assets from prior integrations where appropriate, and provide overall support. On an overall basis, Scott Burghoff will serve as the program leader for UnitedHealthcare, reporting to me. [Scott Burghoff] will partner with Sanj Balsara from PacifiCare in leading the overall coordination efforts.

Among other advantages, these "3 in the Box" teams benefited from historic knowledge from both companies, and received input from the business lead whose operations would be directly impacted by the integration initiative in question. These teams also worked under an explicit "Do No Harm" principle.

Mr. Boeving's criticism about the absence of a single point of responsibility is not well taken. Given the size and complexity of this integration, utilizing separate functional steering committees to oversee individual project initiatives was the right way to manage the process though the integration.[4] PacifiCare/United utilized a separate program management team to coordinate between all of these various teams and committees on issues that had a cross-business impact. At the top of this integration structure sat an Advisory Council, which in essence acted as a Board of Directors and was ultimately responsible for major integration decisions and the results of the integration. Based on my experience with integration projects of this magnitude, this was an appropriate structure.

Another principle of effective program management that United/PacifiCare exhibited was flexibility with respect to execution of the integration strategy. This principle is critical where, as here, the opportunity to conduct more thorough fact-finding takes place after, and not before, the transaction closes. PacifiCare and United had their first opportunity to begin detailed evaluations of their respective platforms and products post-merger. Not unexpectedly, these post-merger evaluations resulted in the evolution of particular going-in strategies.

A good example of PacifiCare/United's flexibility was its execution of the RIMS migration strategy. Pre-merger, PacifiCare/United devised a preliminary strategy to migrate PacifiCare HMO and PPO claims processing functions to United's UNET claims platform.[5] United has an established track record of consolidating claims

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[4] The company in fact did have a single point of accountability for the integration. In 2006, David Astar had ultimate accountability; in 2007, Dirk McMahon took over much of that accountability with respect to PacifiCare's operations and technology.

[5] Merged healthcare companies invariably seek to consolidate claims platforms. Such consolidation improves quality, turnaround times and consistency in claims adjudication and other business processes. This consolidation also serves the goal of relying on the more technologically advanced platform(s). Similarly, companies seek to consolidate "front end" systems that receive claim and other information from providers and other external sources, such as PacifiCare/United did with respect to "UFE."

platforms acquired through mergers. The RIMS platform was an apt candidate for consolidation. Although RIMS was perfectly capable of performing its core functions (accurate and timely payment of claims), RIMS' technology precluded its use as a long-term strategic platform. After a detailed evaluation and within a few months of the merger, the initial strategy evolved. By mid-2006, a decision was made to retain the NICE platform, sunset RIMS and migrate the PLHIC PPO membership to comparable, fully-insured PPO products adjudicated on the UNET platform. Moving the PLHIC PPO membership, instead of migrating PLHIC claims adjudication, to UNET was a sound, low risk strategy.

Mr. Boeving's report highlights negative statements in a couple of internal memoranda and "lessons learned" documents, and seeks to draw conclusions about PacifiCare/United's management and execution of the integration project, as well as PacifiCare's day-to-day operations. Rather than reflecting negatively on the company, however, these internal documents show a culture that was self-critical and highly motivated to learn from past experience and implement process improvements. The sheer quantity of emails, presentations, corrective action and "lessons learned" materials generated during and after the integration evidences the large number of personnel assigned to the integration project and the care with which specific aspects of the integration were monitored. Management responses within these documents shows that management took these issues seriously, focused on identifying and resolving them as they occurred, and then put in place corrective and preventative mechanisms to limit future problems. In short, it would be abnormal in such a large, complex integration project to not have challenges arise. The fact that these internal documents directly and timely addressed certain challenges reflects positively on PacifiCare/United's management of the integration and does not provide a basis to show fault.

VI. PacifiCare/United Leadership Appropriately Managed Significant Challenges To The Integration.

No one suggests that the integration was perfectly executed. Senior executive David Wichmann candidly acknowledged that certain challenges did occur in Point of Service (HMO) claims handling, Group Services and the CTN transition. Every transaction of this magnitude experiences challenges. Nevertheless, the company applied well-tested and effective program management strategies to the integration using people committed to achieving a good result.

Particular challenges experienced by PacifiCare/United heightened the difficulty of this integration process. First, CTN's termination of United's access for its members to CTN's provider network necessitated a provider network contracting process extraordinary in both size and time constraints. In short, United was forced to re-contract with thousands of doctors in a six month time frame. In my experience, that amount of re-contracting is unprecedented in California or outside of it. The termination of the network six months earlier than anticipated also created a huge disruption in the marketplace, significant provider agitation, and required application of extensive company resources to address. Moreover, it necessitated creating a single source of truth earlier than anticipated to prevent having to use two sets of independently updated provider demographic data for one network.

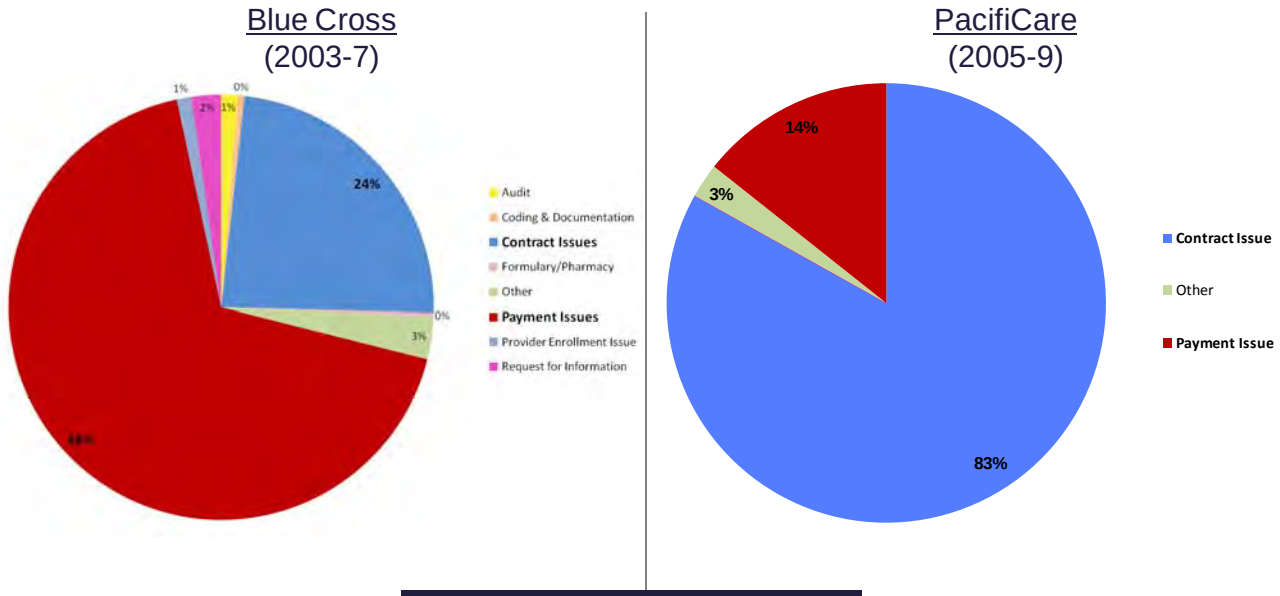
Second, the combined companies had to transition and upgrade important processes from manual to automated promptly after the merger. Prior to the merger, PacifiCare had recognized that certain functions, such as its mail distribution and eligibility data entry, employed antiquated processes that posed significant business risks that necessitated transitioning away from these processes post-merger. And, while operational issues often arise in such transitions, these issues may have nothing to do with flaws in the design or implementation of the process. Rather, the issues reflect the inherent complexity of transitioning from a manual to automated process, and the inherent challenges created by a workforce learning new processes. Accordingly, the mere fact that there were some issues does not show that the project's design or implementation was flawed or related to PacifiCare/United's management of the integration.

Despite the significant challenges PacifiCare/United faced, its management handled those challenges appropriately without materially impacting PLHIC PPO claims-handling performance. In fact, the combined companies were focused on maintaining and improving overall performance. For example, as part of the integration, the combined companies implemented internal targets for timeliness that were more strict than the law required. Additionally, United put in place at PacifiCare a rigorous quality control program, including a separate unit dedicated to internal quality assessment and audits, with specific auditors assigned to the PLHIC PPO business. United also brought to PacifiCare reliance on the 'six sigma" philosophy for process

improvement and quality. As a result of these process improvements, PacifiCare/United's claims payment timeliness performance met or exceeded industry accepted benchmarks during the Market Conduct Examination period.[6]

Mr. Boeving criticizes PacifiCare/United's focus on claim payment timeliness metrics even though this is an industry standard claims handling metric. Using such a metric, in conjunction with other standard metrics, to assist in managing the business was proper and consistent with industry best practices. By contrast, Mr. Boeving's reliance on anonymous, unsubstantiated broker surveys and anecdotal complaints, instead of standard industry metrics and operational data, provides no credible support for his conclusions. Similarly, and contrary to Mr. Boeving's suggestion, the type of claims platform availability metrics tracked for RIMS and described by Divina Way is commonly known in the industry as service availability metrics, and are quite useful and appropriate. They show that the RIMS platform has been quite stable and reliable post-merger.

As indicated earlier in this report, all significant healthcare integrations experience some challenges or problems. I reviewed data obtained from the California Medical Association (CMA) concerning provider complaints or calls CMA received and tracked in connection with the PacifiCare/United and Anthem/Wellpoint mergers. Without going into the validity of any particular complaint or issue, CMA notes that provider complaints concerning claims payments made up 68% of the issues arising out of the Anthem/Wellpoint merger, while complaints on such issues were only 14% the inquiries CMA received for PacifiCare/United. It appears that, at least from the CMA membership's viewpoint, claims payment issues were proportionally a much greater issue in the Anthem/Wellpoint merger than in the PacifiCare merger.



Blue Cross	Category	PacifiCare
68%	Payment/Processing	14%
24%	Contract Issues	83%
2%	Info Requests	N/A
6%	All Other	3%

A. Mailroom and Automated Correspondence Outsourcing

By early 2005, for business and regulatory reasons, most national payers and large third-party administrators had already concluded that they needed to adopt, and had implemented, automation strategies. Even many

[6] United's focus on claims handling performance has been recognized by the provider community. In the American Medical Association's fourth annual National Health Insurance Report Card, United was ranked first among major, national health plans in claims payment timeliness and accuracy.

mid-sized payers (but not PacifiCare) had put certain automated processes in place.[7] PacifiCare's legacy manual document handling processes were not only atypical for a company its size, but also created considerable risk to its business. Recognizing the risks, PacifiCare pre-merger had begun to automate and outsource some of its mail rooms, and had decided to automate and outsource its Cypress mail room functions using a vendor, ACS. Mr. Boeving does not appear to take issue with the company's decision to automate and outsource these mailroom functions, which is not surprising because outsourcing is a frequently employed industry strategy for mailroom operations.

Post-merger, PacifiCare simply proceeded with pre-merger strategy albeit with a different vendor, Lason. The switch from ACS to Lason was the only change PacifiCare/United implemented from the pre-merger plan, and was based, in part, on significant variances in performance (as measured by specific metrics) between the two companies. Ultimately, Lason's operations and historical performance were better suited to handle the complexities of PacifiCare/United's businesses. For purposes of planning the automation process, the Lason transition team relied on knowledgeable PacifiCare subject matter experts to design the overall workflow solution (the same team tasked with the project pre-merger).

PacifiCare/United experienced challenges with the mailroom transition, as one would expect. Approximately 85% of PacifiCare's incoming mail is claims, for which there appears to have been very few issues. The operating issues that did occur in large part were isolated to the small subset of "non-keyable" correspondence that represented the most complex portion of the business document flow.[8] Further, the issues that did occur do not appear to have been caused by cost cutting or going too fast with the project planning or implementation. Indeed, Jonathan Murray and a team of legacy PacifiCare employees spent months designing and testing the system. Rather than moving too quickly, moreover, the implementation in fact was phased over a period of months.

Mr. Boeving makes an off-hand statement that the Lason issue impacted claims handling. Mr. Boeving does not cite, and I have not seen, evidence that Lason or mailroom issues in fact resulted in any material impact on PacifiCare/United's claims-handling performance. To the contrary, the evidence I have examined indicates that a significant amount of resources were directed to solving problems with the attention of high level executives and operational leaders.[9] The operational and integration teams performed deep dive reviews, vendor/company summits, and assigned full-time integration teams to investigate and resolve issues as they occurred. As a result, Lason did not materially impact claims handling performance during the Market Conduct Examination period and continues to perform very well today.

B. Eligibility Outsourcing

Standardizing eligibility forms and outsourcing data entry functions to a third-party vendor like Accenture is an industry leading practice.[10] In contrast, PacifiCare historically did not insist on, or make available, standardized forms or standardized operating procedures to insureds and, as a result, produced inconsistent eligibility

[7] Significant legislative mandates for healthcare in the last decade, including those arising from HIPAA and Sarbanes Oxley, require implementation of robust automated document tracking and imaging systems. These mandates bring significant benefits to health plans to ensure regulatory and financial compliance. Document tracking and imaging helps safeguard information and ensures the security of the information. It provides an audit trail to document access to the documents. Imaged documents also provide a non-erasable format to protect documents from tampering.

[8] Member and provider correspondence presents complex issues for all health plans, because of significant variations in the format and substance of the documents that are received.

[9] Mr. Boeving takes issue with PacifiCare/United having not assigned a single overall leader for the Lason mailroom transition and day-to-day activities. However, there was appropriate oversight -- Ellen Vonderhaar, VP of Transactions (Claims) was responsible for Lason's day-to-day performance with respect to PacifiCare operations, and Kelly Vavra, VP of Data Capture, was responsible for Lason's contract, relationship and enterprise-wide performance. These executives and their teams were actively involved in overseeing Lason's work, regularly communicated with Lason staff and were actively engaged in resolving issues and improving Lason's performance.

[10] Benefits of outsourcing include cost savings, access to knowledgeable expertise, and the ability to manage capacity and staff. Also, a well-executed and disciplined approach to eligibility greatly improves overall quality and operational efficiencies.

information. In addition, legacy PacifiCare's processes around eligibility were fraught with non-uniform processes and undocumented special handling/business rules. This lack of standardization created an unreasonably high enterprise risk, and continued use of such a model was not in the best interests of members, employers, brokers, or the company itself. Not surprisingly, PacifiCare was planning to implement changes to these processes pre-merger.

While Mr. Boeving takes issue with a change in the legacy PacifiCare service model away from a "high touch" model, the scope of the Accenture outsourcing agreement covered eligibility data entry only, and did not include any processes related to product and benefit design or case installation, which remained in Cypress. Moreover, "high touch" does not necessarily equate with "high quality service." As acknowledged by legacy PacifiCare employee and CDI witness Ruth Watson, PacifiCare's "high touch" model involved dedicating multiple people to staff an inefficient and error-prone process. Although brokers, employers and members may have appreciated access to a personal customer service representative who would help fix these errors after-the-fact, the better approach would be to avoid the errors in the first instance.[11]

C. RIMS Upgrading and Maintenance

PacifiCare/United made well-reasoned decisions pre- and post-merger with respect to upgrading and maintaining the RIMS claims platform. I have seen no evidence that any of those decisions resulted in a material negative impact on PacifiCare's claims-handling performance.

PacifiCare undertook RIMS upgrade projects both before and after the merger when there was a business or regulatory need. For example, in order to address HIPPAA compliance requirements, PacifiCare engaged in a complex project in May 2004 to upgrade RIMS from version 2.80 to 3.10.50. A team of IT personnel required a year to complete the upgrade, which created a clear benchmark for the time and complexity involved for any additional upgrades that might be considered in the future. Also, capital expenditures were made post-merger to modify and improve the RIMS system as necessary to meet regulatory and operating needs, including upgrading RIMS to version 3.10.70.

Mr. Boeving criticizes PacifiCare's decision to not upgrade to version 3.20/3.30, but he does not demonstrate that PacifiCare's decision caused any late paid claims or any material impact on PacifiCare's claim handling performance. PacifiCare considered and rejected the 3.20/3.30 upgrade both prior to the merger in 2004/2005, and again in 2006. Those decisions were based, in part, on the significant time and complexity that would be involved in changing to the 3.20/3.30 version, which would have entailed rewriting hundreds of customized programs (many of which were interdependent), obtaining new hardware, and re-training users. Indeed, the much simpler upgrade to version 3.10.50 in 2003-2004 had taken a year to implement. The company also determined that there was not a sufficient business need to undertake the upgrade because the then-current version was performing all necessary business functions. Moreover, while Mr. Boeving cites the relational database and SQL search functionality as the most significant justification for the upgrade, PacifiCare already had that functionality in conjunction with the version of RIMS software it was using.

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[11] Separate from the transition of eligibility data entry to Accenture, there were some changes in the customer service touch points for brokers and employer groups post-merger. These changes were implemented in order to lessen administrative burdens on brokers and insured groups, reduce defects and improve efficiency. It is typical in a merger that a company's touch points with its stakeholders change. This change inevitably creates some amount of resistance and, as a practical matter, it takes time and communication to overcome this initial resistance. Nevertheless, this resistance by stakeholders is not indicative of poor integration planning or implementation. Companies do learn when implementing changes; here, the complaints from stakeholders received the attention of senior executives and PacifiCare/United modified its broker service model and eligibility processes as appropriate. But it is wrong to criticize a company for implementing positive changes or for taking steps to remedy issues arising from well-intended improvements to existing processes.

As to PacifiCare's maintenance of the RIMS platform post-merger, budgeting and spending remained consistent with pre-merger spending:

(in millions)	2005	2006	2007	2008
Costs (non-capitalizable)	$3.7	$3.1	$2.6	$2.7
Development capitalized	$2.8	$1.4	$3.0	$2.6
Total	$6.5	$4.5	$5.6	$5.3

As to the availability of RIMS, the service availability metrics used by PacifiCare to monitor this platform were entirely appropriate. Sophisticated electronic claims systems, which are comprised of literally hundreds of separate software programs and numerous pieces of hardware, are constantly subject to operational issues. Most such issues are minor, e.g., a person or small group of users cannot get access to one part of the overall system. Given the differing type and severity of possible system "malfunctions," PacifiCare/United's availability metrics measure realistically the degree to which a computer system is capable of accomplishing the company's business at any given time.

Although Mr. Boeving characterizes PacifiCare/United's approach to RIMS as "do just the minimum to keep the system up and running," my opinion is that PacifiCare/United acted as any prudent, well-managed organization would to ensure that a system, which is not a long-term strategic platform, operates properly. In my experience, major healthcare plans use different processes to set capital expenditure and maintenance budgets. PacifiCare's differed from United's, and there was a learning curve for legacy PacifiCare employees in adjusting to the United budgeting processes. All well-managed companies, however, have rules around keeping actual spending within their budgets, unless business, legal or operational issues require deviation. That was the situation within PacifiCare/United, and there is nothing negative or blameworthy about it.

Rather, the true measure of whether PacifiCare/United properly maintained RIMS should be how the system performed.[12] I have not seen evidence of an instance in which PacifiCare/United's maintenance of, or capital expenditures for RIMS, is tied to a purported negative impact at issue in this proceeding. The one major outage that RIMS suffered in the relevant period was related to a lightning strike on a data center facility. This event clearly was anomalous, and was unrelated to PacifiCare/United's maintenance of the RIMS platform. In short, RIMS was maintained in a manner such that it was an extremely stable claims-handling platform in terms of its availability to do work throughout the integration period.

Further, Trizetto's level of support did not change over time. Trizetto and other key software vendors contractually agreed to continue their support. While Mr. Boeving speculates that the quality of vendor support was "likely substandard," in fact Trizetto used the same personnel pre- and post-merger to service RIMS.

D. Single Source of Truth for Data -- EPDE

For many years, the healthcare industry consistently has recognized that a single source of truth for data is necessary to improve data quality and reduce processing discrepancies. After termination of access to the CTN rental network, both the PacifiCare and United California PPO members needed to rely on the same provider network for access to medical care. Because this membership was initially serviced by two separate claims platforms and two separate networks, two independent provider demographic data sets existed. Given that both

[12] I have seen questioning of PacifiCare/United witnesses in this proceeding suggesting a negative connotation to the term "Keep The Lights On" (KTLO) and its implementation. There is nothing negative about the term. In my experience, the term and its usage is commonplace in the IT and healthcare industry. With respect to a variety of non-strategic systems and operational tools that ultimately would be subject to consolidation with, or no longer used in favor of, more technologically advanced platforms, PacifiCare/United quite properly implemented a KTLO approach led by a committee (staffed with legacy PacifiCare personnel to provide historical knowledge) to maintain and improve these platforms and tools as appropriate.

memberships were accessing one network, the best practice was to combine the two demographic sets and establish a single source of truth as soon as reasonably practicable after the transition from CTN.

Using an automated tool to replicate data between two disparate systems, and achieving a single source of truth, has been a common practice in the health insurance industry for over ten (10) years. The EPDE replication technology used here to link United's NDB to RIMS was the standard architecture successfully utilized by United previously to manage provider data from a single source of truth in other markets. Industry standard methods were utilized to design, test and implement EPDE for application to RIMS.

Mr. Boeving refers generally to unspecified problems with PacifiCare's provider data without providing any evidence or analysis to support his statements. He does not demonstrate that any such issues had any material impact on PacifiCare's claims-handling performance. Nor does Mr. Boeving establish that any of the provider data issues he raises were actually caused by EPDE. As a result, Mr. Boeving incorrectly assumes that, because there apparently were issues with provider data, those problems reflected poorly on the design and implementation of the EPDE tool. The issue is far more complex. Provider demographic data presents certain peculiar complexities (source, nature and continuing evolution of data) for all health plans.[13]

Consistent with those industry problems, pre-merger PacifiCare had its own provider data issues. For example, the number of returned checks issued to providers actually decreased after the implementation of EPDE. Consequently, it is wrong to blame EPDE for all post-merger provider data issues. In any event, an experienced, dedicated EPDE team was tasked with monitoring and controlling the process. Issues were appropriately detected and corrected. Further, PacifiCare/United was able to confirm that implementation of EPDE outside of California improved data quality over time.

Mr. Boeving's report suggests that, as an alternative to the EPDE tool, RIMS should have been upgraded in 2006 to version 3.30 and then a "direct connection" should have been established between NDB and RIMS for provider demographic data. As discussed above, however, upgrading RIMS was considered by PacifiCare both before and after the merger, and rejected for multiple, valid reasons. Moreover, Mr. Boeving's direct connection "solution" would have been technologically impractical and, in any event, would not have prevented or fixed anything because EDPE, an EPDE-like tool, or a similar translation device would still have been needed due to differences in the data structures between RIMS version 3.30 and NDB.

This concludes my report.

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[13] Indeed, in order to reduce at least some of the unnecessary processing costs and help control for the constant changes in provider data, major healthcare organizations have utilized precisely the kind of processes reflected here: enterprise data integration and a "single source of truth" as a standard practice.

APPENDIX A

Rick McNabb

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Education

- Bachelor of Business Administration, Finance, University of Oklahoma
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Rick McNabb, Managing Partner, is responsible for leading **Optimity Advisors**. He brings more than 30 years of expertise in financial, accounting and information technology, reengineering and strategic services for healthcare, insurance and financial services industries. Because of extensive consulting experience, he is focused on leading and delivering large, high risk and strategic projects.

Professional Experience

Major accomplishments include:

- Rebuilt the Federal Employees Program healthcare operations for the Blue Cross Blue Shield Association. This program administers healthcare benefits to 54% of federal workers excluding department of defense. The project delivered many operational and technical benefits to enable the program to continue to be service and cost competitive for many years. The project was delivered on time and on budget accounting for 450,000 hours of effort over five years. This operational transformation was the largest single instance claims operations implementation in the last twenty years.

- Created and led the Legacy Transformation and SOA Solution service lines to our clients. Efforts include the creation of business cases for internal funding, detailed methodology, proof-of-concepts, points of view, training programs, marketing material, and analyst communications.

- Developed operational transformation strategy and plan in the industry for large commercial payer. This plan led to the complete reconstruction of the healthcare company.

- Designed and operationalized the consumer-directed product suite for a national insurance carrier in order to grow market share.

- Redesigned and implemented new nurse triage call center for specialty care business.

- Performed requirements definition, package evaluations, selection and implementation of several integrated managed care systems. Functions included medical management, claims/encounters, membership and financial reporting. The projects utilized a packaged-enabled reengineering approach to assure cost-effective high-value operational impact.

- Led due diligence efforts to separate Prudential Healthcare and merge into Aetna operations.

- Selected and implemented several general ledger systems impacting the financial reporting and capital management processes. Value included improved performance measures, streamlined financial processes and improved return-on-equity positions.

- Developed several information technology and e-business strategic plans for Blue Cross/Blue Shield Plans and national insurance companies including the development of application, information and technology architectures. Value created was to assure strategic resources and initiatives were aligned with the strategic business directions.

- Implemented intelligent character recognition and a simplified underwriting solution for a new business function for a third party administrator. The benefits allowed this administrator the ability to conduct large high quality open enrollment with a minimum of staff.

- Developed a capital management strategy along with the associated management processes to improve overall return-on-equity. The estimated benefit of the project was a 3% increase in ROE, yielding a bottom-line benefit of $210 million. Included in the project was a better decision-making process for ROE improvement (e.g., capital redeployment, asset/liability parameters, investment return, and product design).

- Designed and built an international reinsurance system to bring to market and manage niche products in multiple European, South American, and Asian markets. This system allowed the company to gain international market share and manage risk profitably.

APPENDIX B

ATTACHMENT B

Project Management Guidelines

Guideline	Definition	PacifiCare/United applied?	Example
Integration Management	Activities that integrate project management (project charter, change control, etc)	✓	Provider Data Integration project - developed project charter/scope document that included background, scope, team organization chart, roles and responsibilities, critical success factors, milestones, deliverables, assumptions, constraints, dependencies, risks, sign-off)
Time Management	Ensures timely completion of project (project schedule)	✓	Project schedules included workplan tasks, start dates, completion dates, % complete, task owners (United and PacifiCare), and status/comments
Cost Management	Planning, estimating, budgeting and controlling costs	✓	Evidence of detailed budgets as well as tracking of costs through project lifecycle (e.g., FIT)
Quality Management	Planning, monitoring, controlling and assuring quality requirements are achieved	✓	Quality organization established with 15 dedicated persons. Quality audit processes established that consisted of the following quality audits: • Statistical Audits / Post disbursement audit • High dollar audits • Performance Guarantee audits • Auditor Validation
Risk Management	Identifying, analyzing, and controlling risks for the project	✓	Risk mitigation plans developed that included identification, mitigation, tracking, resolution, etc.
Human Resources Management	Planning, acquisition, development and management of the project team	✓	Well defined project organization and governance structure with roles and responsibilities (PMO, project leads, SMEs, key stakeholders)
Communication Management	Ensuring timely and appropriate generation, collection, dissemination, storage, and ultimate disposition of project information	✓	Weekly status reports developed for each project. Status reports contained standard types of reporting (status, issues, milestones/deliverables, accomplishments, etc). Integration team met weekly to discuss status and Steering Committee met every other week to discuss status and make decisions. Performance tracked and communicated post merger
Issue Management	Identifying, analyzing, and resolving issues for the project	✓	Detailed issue logs for initiatives. Issue logs identified dates, issue identifier, status, issue description, and action
Scope Management	Ensuring project includes all work required to successfully complete project. Putting change controls in place if a change in scope is required	✓	Change in RIMS migration strategy. Team evaluated pros, cons, risks, impacts of change in scope, and made decision based analysis

APPENDIX C

Appendix C

Documents

342	5191	5396	5462
377	5248	5396	5463
426	5252	5397	5464
432	5255	5399	5465
434	5262	5443	5466
439	5264	5444	5467
457	5264	5445	5468
517	5265	5446	5469
604	5296	5447	5481
625	5341	5454	5482
647	5344	5455	5486
695	5369	5455	5503
797	5370	5457	5505
943	5394	5457	5539
984	5395	5458	

CDI00252888 - CDI00252911

PAC0009501 - PAC0009507

PAC0009789 - PAC0009834

PAC0023490 - PAC0023499

PAC0093424

PAC0099230 - PAC0099248

PAC0100091 - PAC0100118

PAC0101549 - PAC0101550

PAC0228260

PAC0315689 - PAC0315691

PAC0315710 - PAC0315713

PAC0338370 - PAC0338384

PAC0339963 - PAC0339993

PAC0421225 - PAC0421259

PAC0477778 - PAC0477857

PAC0590864 - PAC0590865

PAC0622653 - PAC0622674

PAC0626209 - PAC0626217

PAC0626249 - PAC0626256

PAC0644159 - PAC0644172

PAC0649883 - PAC0649891

PAC0651361 - PAC0651363

PAC0772596 - PAC0772597

PAC0777131 - PAC0777151

PAC0777357 - PAC0777358

PAC0777377 - PAC0777379

PAC0778078 - PAC0778092

PAC0791293 - PAC0791298

PAC0805190 - PAC0805225

PAC0806138 - PAC0806170

PAC0817271 - PAC0817284

PAC0821869 - PAC0821904

PAC0834391 - PAC0834392

PAC0835324 - PAC0835341

PAC0836556

PAC0837090 - PAC0837147

PAC0842908 - PAC0842921

PAC0843025 - PAC0843026

PAC0843271 - PAC0843273

PAC0843754 - PAC0843758

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PAC0879684 - PAC0879709

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PAC0909568 - PAC0909610

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WellPoint - WellChoice Merger Press Release,
<http://ir.wellpoint.com/phoenix.zhtml?c=130104&p=irol-newsArticle&ID=799275&highlight=>

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Testimony

Excerpts of testimony from the following witnesses:

Susan Berkel

Scott Burghoff

Joan Goossens

Jason Greenberg

Sam Ho, M.D.

Albert Labuhn

Ross Lippincott

Elena McFann

Dirk McMahon

Nancy Monk

Jon Murray

Ellen Vonderhaar

Kelly Vavra

Ruth Watson

Divina Way

Dave Wichmann

PROOF OF SERVICE

I, Deborah Waterford, 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 SNR Denton US LLP, 525 Market Street, 26th Floor, San Francisco, California 94105. On July 1, 2011, I served:

EXPERT REPORT OF RICK McNABB

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 LaKeitha Oliver Strumwasser & Woocher LLP 10940 Wilshire Boulevard Suite 2000 Los Angeles, CA 90024 mstrumwasser@strumwooch.com bgee@strumwooch.com loliver@strumwooch.com Via Electronic Mail Only	Andrea Rosen California Department of Insurance Legal Division Health Enforcement Bureau 300 Capitol Mall, 17th Floor Sacramento, CA 95814 rosena@insurance.ca.gov

☒ **(By Mail)**: I am personally and readily familiar with the business practice of SNR Denton US 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 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 1, 2011, at Oakland, California.

Deborah Waterford

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