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18 **BEFORE THE INSURANCE COMMISSIONER**
19 **OF THE STATE OF CALIFORNIA**

20 In the Matter of
21
22 PACIFICARE LIFE AND HEALTH
23 INSURANCE COMPANY,
24
25 Respondent.

26 File No. UPA 2007-0004

27 OAH No. 2009061395

28 **EXPERT REPORT OF DANIEL
KESSLER**

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REPORT OF DANIEL KESSLER

I. INTRODUCTION

A. My Background

I obtained a JD from Stanford Law School in 1993 and a PhD in economics from M.I.T. in 1994, specializing in law-and-economics and health economics. I am currently a tenured professor at Stanford Law School and the Stanford Graduate School of Business; a professor (by courtesy) at the Stanford School of Medicine; a senior fellow at Stanford's Hoover Institution; and a Research Associate at the National Bureau of Economic Research, the nation's leading nonprofit, nonpartisan economic research organization.

I have published numerous papers in peer-reviewed journals on health economics, health insurance, and regulation. Several areas that have been a focus of my research are directly relevant to this matter, including the application of the theory of deterrence to problems of regulatory policy, enforcement, and optimal penalties in civil and criminal settings. My research has been cited by the National Association of Insurance Commissioners (NAIC), the U.S. Congressional Budget Office, and the *New York Times*. I have served as a consultant on health economics and policy issues to the U.S. Federal Trade Commission, hospitals, and insurers. I have received grant support from the U.S. National Institutes of Health, the National Science Foundation, the Agency for Health Care Research and Quality, the California Health Care Foundation, the American Cancer Society, and the Commonwealth Fund. My full curriculum vitae is attached as Appendix A.

B. Scope Of Assignment

My report addresses the following issues within the context of Dr. Zaretsky's testimony and related allegations by CDI:

1. According to economic principles, how should penalties be determined and what penalty, if any, is appropriate here?
2. What relevance, if any, do CDI's dealings with providers have in this case?

C. Summary Of Conclusions

In response to these questions, I reached the following conclusions:

1. According to economic principles and the applicable regulatory standards, no penalty is appropriate in this case. The primary goal of insurance regulation should be to promote the well-being of consumers through a balancing of costs and benefits of regulation. That means regulators should *not* assess

penalties in a way that would deter *all* claims-handling errors, since requiring perfection would entail extremely high compliance costs, which would ultimately be borne by consumers. Instead, penalties should be related to harm, not gain, and inversely related to the probability of detection. In this case, harm was minimal, compensation was paid years ago, and the probability of detection was essentially certain. Further, the lack of transparency and notice that the conduct at issue violated the law, combined with the absence of consistency in treatment of PacifiCare here, mean that penalties will not accomplish their intended objective of protecting consumers.

If the decision maker in this case determines that some penalty is appropriate, it needs to be consistent with historical penalties imposed by CDI for similar cases over the past decade. When these historical penalties are adjusted to the facts of this matter, they establish a penalty range of between \$0 and \$655,289. A penalty outside of this range, particularly one of the size contemplated by CDI, would create tremendous regulatory uncertainty that would discourage future investment and entry into the California market, reduce competition, and harm California consumers. The closest of these past cases to the current case is United Multistate. Adjusted to the circumstances of the current case, the penalty imposed in the United Multistate matter implies a penalty in this enforcement action of \$182,949.

2. CDI's dealings with providers in this case are relevant because they evidence that CDI became "captive" to those special interests in this particular instance and that, as a result, the traditional deference that might otherwise be accorded the regulator should not be accorded here. Indeed, those communications lead me to conclude that this action is not serving consumers' best interests.

D. Documents Reviewed

As part of my work, I reviewed numerous documents including pleadings, research literature, CDI publications, the CDI website, CDI's expert testimony, NAIC material, testimony in this matter, and other items, which are listed at Appendix B.

II. ACCORDING TO ECONOMIC THEORIES OF DETERRENCE, NO PENALTY IS APPROPRIATE IN THIS CASE

The economics literature on the theory of deterrence and public enforcement of law is clear: the goal is to assess penalties in a way that exactly balances the costs and benefits of regulation. The goal is *not* to assess penalties in a way that would deter *all* claims-handling errors, since requiring perfection would entail extremely high compliance costs

and not be in consumers' best interests.¹ This literature has established three fundamental principles relevant to this matter:

- Harm to consumers -- not the gain to violators -- should determine the magnitude of penalties.
- When penalties are appropriate, they should be inversely related to the probability that a violator will be detected. In other words, the higher the probability that a violation will be detected, the lower the amount of the penalty.
- Other factors, such as need for transparent and consistent enforcement, should also be considered in the assessment of penalties.

This economic theory is reflected in the applicable regulatory scheme set forth in Section 2695.12(a). The most-mentioned factor is harm in Sections 2695(a)(10) and (a)(12) (refers to harm directly) and (a)(7) (refers to the scale of the non-compliance). Subsection (a)(8)'s reference to the licensee's remedial measures is consistent with the theory of deterrence's imposition of lower penalties when affected parties have already been made whole. Subsection (a)(13)'s reference to management's awareness of the non-compliance is consistent with the principle that effective deterrence requires regulated entities to be informed about the standards that they are expected to meet.²

When these fundamental principles are applied to this case, it is clear that no penalty is appropriate.

A. Penalties Should Be Proportional To Harm, Not Gain

According to Professor Becker's classic 1968 article, which is misinterpreted by Dr. Zaretsky in his report, the fines prescribed by the theory of deterrence are proportional to the harm to consumers, not the gain to the alleged violator. In equation form, F is the fine, H is the harm, and P is the probability of detection:

$$F = \frac{H}{P}.^3$$

¹ See 10 CCR Sec. 2695.1(a)(2) recognizing the need for balancing in its statement that the statute should "promote the good faith, prompt, efficient and equitable settlement of claims *on a cost-effective basis* [*italics added*]."

² Peer-reviewed research by Professors Polinsky and Shavell point out that factors such as repeat-offender status, good faith, and intent (Subsections (a)(9), (a)(11), and (a)(13)) fit within the economic framework as well. A. Mitchell Polinsky and Steven Shavell, On Offense History and the Theory of Deterrence, *International Review of Law and Economics* (1998) 18: 305-24 and Steven Shavell, Criminal Law and the Optimal Use of Nonmonetary Sanctions as a Deterrent, *Columbia Law Review* (1985) 85: 1232-62.

³ Gary Becker, Crime and Punishment: An Economic Approach, *Journal of Political Economy* (1968), Vol. 76 No. 2, pp. 169-217. In all of the analysis that follows below, I assume that the violator pays the regulator for the costs of enforcement, over and above the fine and the penalty, and so exclude that amount from my calculations.

The fine specified by the theory of deterrence can be written as the sum of two components. The first is compensation to consumers or providers for the harm that they suffered. The second is the penalty to be paid to the regulator. In equation form:

$$F = \frac{H}{P} = H + \left(\frac{1-P}{P} \times H \right).$$

The economic literature on deterrence is clear -- the focus is on harm, not gain. All subsequent scholarship confirms Professor Becker's original insight.⁴ This is important in this matter because Dr. Zaretsky appears to be relying on this literature for his key opinion and yet his version of the model (where penalties should depend on gains) is nowhere to be found in it. Fines based on gains are not in consumers' best interest (except in those rare instances where the harm exactly equals the gain). In any situation where the harm is less than the gain, gain-based fines lead potential violators to make decisions that are more costly than the harm that was to be deterred in the first place.⁵

⁴ All subsequent scholarship confirms Professor Becker's original insight. Indeed, two of the country's leading law-and-economics scholars have written a paper specifically emphasizing that liability should be based on the harm to victims rather than on the gain to violators. See A. Mitchell Polinsky and Steven Shavell, *Should Liability Be Based on the Harm to the Victim or the Gain to the Injurer*, *Journal of Law, Economics, and Organizations* (1994), Vol. 10 No. 2, pp. 427-37.

⁵ Consider an example in which an insurer can make investments in its operations that will ultimately improve customer service and reduce its operating costs, allowing it to charge lower prices to consumers. Assume that the gains from the investment, net of its cost, are \$1,000. However, in the short run, the investment will cause minor disruptions, and the harm from these disruptions is \$100. If the insurer's decisions are known to the regulator with certainty, then imposing a fine of \$1000 (or a little more) would eliminate any incentive for the insurer to make the investment.

B. The Alleged Violations Caused Minimal Harm

To help determine what the penalty should be in this case, I evaluated the magnitude of harm focusing on the major categories of alleged violations (representing over 98% of the alleged violations at issue) as set out in Figure 1:

Figure 1: Categories Of Alleged Violations In This Case

#	Alleged Violation	Violations Alleged	Additional Payments
1	Omission of form language in EOP: failed to include language specifying CDI right to review and contact information on EOP.	443,406	\$ 0
2	Omission of form language in EOB: failed to include form language related to possible right to an Independent Medical Review.	322,605	\$ 0
3	No written provider acknowledgment letters with 15 working days	102,295	\$ 0
4	Failure to retain copies of acknowledgment letters	62,333	\$ 0
5	Failure to reimburse an uncontested claim within 30 working days	42,143	\$ 0
6	Failure to pay interest on uncontested "late pays"	5,435	\$ 156,455

There is nothing in either Dr. Zaretsky's or Mr. Boeving's report, nor any evidence of which I am aware, that would support an assessment of harm in any categories other than 6. CDI's final audit reports confirm that fact. The discussion of harm to consumers and providers in Dr. Zaretsky's report is general and speculative in nature. It is anecdotal and non-specific. It does not even seek to attach a dollar amount to the harm that it alleges to have occurred.⁶ Appendix C presents a detailed basis for my independent conclusion that no harm exists beyond the \$156,455 referenced above.

CDI's allegations regarding complaints from health care providers and consumers about PacifiCare and United -- which form the basis for its claim that there was significant harm in this case -- grossly overstate the actual number of valid complaints *according to CDI's own data*. In summary, a total of 674 complaints were opened from December 2005 to January 2008 (181 were from providers and 493 were from consumers). The vast majority of complaints were not associated with a violation. Only 196 complaints were even associated with any violation of law at all and, of that number, there were only 28 complaints with a justified violation from a health care provider, and there were 86 complaints with a justified violation from a consumer. Details of my analysis are in Appendix D.

⁶ The other alleged violations constituting less than two percent of the total were either not addressed by Dr. Zaretsky, caused no harm and/or were self-disclosed to CDI by PacifiCare and remediated prior to the market conduct examination.

C. High Probability Of Detection Means Penalties Are Not Appropriate

As previously discussed, when penalties are appropriate, they should be inversely related to the probability that a violation will be detected. Dr. Zaretsky's estimate of the probability of detection of 0.1 is nowhere supported and unrealistically low, which is one reason why he overstates what the appropriate penalty should be. For the following reasons (many of which are acknowledged by Dr. Zaretsky in his own report⁷) the probability of detection of violations was essentially certain:

- At the time that these violations occurred (and in the preceding year), PacifiCare was the subject of an ongoing market conduct examination (“MCE”);
- The California legislature had just passed a law that imposed new obligations on insurers and required the CDI to respond to alleged violations of providers' rights;
- Providers could be expected to file complaints against PacifiCare because they were in the midst of contract negotiations with it;
- PacifiCare was under scrutiny as a result of its merger with United. In the hearings associated with the merger, Commissioner Garamendi put PacifiCare on notice that CDI would be "totally engaged" in dealing with any provider issues;⁸
- As part of the Undertakings associated with the merger, PacifiCare agreed to provide CDI with periodic reports about its market conduct, including the timeliness of its claims payment. Thus, it is simply unrealistic for PacifiCare's management to have believed that market conduct violations in general, and late payments in particular, would have evaded detection by CDI;
- PacifiCare's management took affirmative steps to disclose certain other alleged violations to CDI months before PacifiCare had notice of the MCE and before CDI became aware of the issues, thereby making their detection certain as well;⁹
- Health insurance is a highly-regulated business subject to review from numerous government agencies; and
- There is nothing in Dr. Zaretsky's or Mr. Boeving's reports, nor am I aware of anything else, that suggests that PacifiCare engaged in any effort to evade detection.

D. The Lack of Transparency, Reasonable Notice And Consistency Militate Against A Penalty Here

Transparency, reasonable notice and consistency in enforcement are not only central to basic due process principles. They are also tenets of effective deterrence theory and economic theory more generally. Effective deterrence dictates that regulated entities be made aware of the actions that are considered by the agency to cause harm to consumers and therefore result in regulatory violations, and that the regulated entities be able to predict when penalties will be assessed and the level of the penalty. Transparency, reasonable notice and consistency in enforcement enable regulated entities to develop efficient plans for both their operations and for regulatory compliance. Transparency and

⁷ Pre-filed report of Dr. Zaretsky, pp. 12-13, lines 26-8.

⁸ Investigatory hearing regarding acquisition of control of PacifiCare Life and Health Insurance Company by United Health Group, November 1, 2005, p. 107.

⁹ Nicoleta Smith testimony, 12/8/09, p. 160.

consistency also benefit consumers by facilitating the achievement of the broader goals of regulation. However, when regulators do not adhere to these principles, they create uncertainty that ultimately harms consumers -- the primary party they are designed to protect. Unpredictability in the regulatory process both discourages investment designed to improve compliance from existing entities and discourages future entry into the California market by out-of-state entities.¹⁰ Less investment and less entry reduce competition, which raises costs and is bad for consumers.¹¹

CDI's actions in this case conflict with these basic principles of the economics of regulation. First, CDI has alleged violations in circumstances in which PacifiCare complied with applicable regulatory standards and specific metrics dictated by CDI. According to the National Association of Insurance Commissioners ("NAIC"), market conduct regulation should consider whether a company's error rate exceeds a minimum threshold of 7 percent. The Undertakings between United-PacifiCare and CDI established clear standards for claims payment timeliness as well -- 92 percent of claims within 30 calendar days, which is equivalent to a benchmark error rate of 8 percent. These thresholds are consistent with Section 790.03(h) of the California Insurance Code, which specifically seeks to punish general business practices.

Second, CDI's allegations conflict with the historical application of some of the language at issue. I understand that the California Legislature adopted the statute requiring acknowledgement of claims submitted to CDI-regulated entities to mirror the regulation requiring acknowledgement for DMHC-regulated entities. As Exhibit 5263 shows, the DMHC did not interpret this law as requiring insurers to proactively send a physical letter to providers or members. Prior to this action, I am not aware of any evidence that CDI had informed its regulated entities that it intended to adopt a contrary interpretation. In other instances, CDI has issued Notices to insurers informing them of its enforcement intentions.¹² Indeed, CDI's decision *not to allege* some violations in this matter that occurred prior to notification of its interpretation of the relevant regulation is consistent with a policy of not imposing penalties without appropriate notice.¹³ Yet, despite this precedent, CDI is now seeking to penalize PacifiCare for failing to send physical letters. These inconsistencies in enforcement decisions conflict with one of the key tenets of deterrence.

Third, CDI's allegations do not even appear to fall within the proscriptions of Section 790.03 and CDI confirmed that view in its final market conduct exam reports. Section 790.03(h) enumerates sixteen categories of violations, none of which include omission of form language from EOBs/EOPs or failing to send or retain letters acknowledging receipt

¹⁰ In "Efficiency Consequences of Rate Regulation in Insurance Markets," Sharon Tennyson concludes regulatory uncertainty reduces the supply of insurance. Sharon Tennyson, Efficiency Consequences of Rate Regulation in Insurance Markets, Networks Financial Institute Policy Brief 2007-PB-03 (March 2007).

¹¹ U.S. Government Accountability Office, Competition in Health Insurance Markets, GAO-09-864R (July 2009).

¹² See, for example, Commissioner David Jones, Notice to all Admitted Health Insurers and Other Interested Persons, Enforcement of Independent Medical Review Statutes, May 17, 2011.

¹³ For example, CDI declined to allege violations arising out of omission of form language in PacifiCare's EOBs and EOPs prior to its communication that such language was noncompliant.

of a claim. The CDI itself expressed the opinion that these violations were not subject to that statute when it very clearly stated that all but 90 alleged violations were something “other than violations of Section 790.03.”

Fourth, more generally, CDI has offered no evidence about PacifiCare's performance relative to that of other insurers. Given that PacifiCare appears to have complied with NAIC standards, the undertakings, and historical interpretation of the relevant statutes, the absence of any comparative evaluation of its behavior enhances my conclusions about the lack of consistency in this matter.

Finally, and perhaps most significant, the penalties that CDI is proposing in this case dramatically exceed its past enforcement practices. As I discuss below, based on Dr. Zaretsky’s report, the penalties that CDI is proposing are approximately *one hundred times* greater than the largest penalty it imposed on any type of insurer in the past eleven years even though the harm to consumers in that case was clearly greater than in this one.

III. CDI'S HISTORICAL PENALTIES ESTABLISH A MAXIMUM RANGE

If the court decides to impose any penalty here, which I do not think would be warranted, it should be consistent with the historical penalties imposed by CDI for similar cases. This is a fundamental principle of regulatory enforcement. When these historical penalties are adjusted to the facts of this matter, they dictate that the only possible penalty range would be between \$0 and \$655,289.

Figure 2 shows that the *total* penalties resulting from *all* legal actions by CDI’s Market Conduct Division over the years 2002 through 2009 have never approached the penalty being proposed in this matter.¹⁴

¹⁴ CDI Annual Reports.

Figure 2: Proposed Penalty Dwarfs Prior Total Annual Penalties

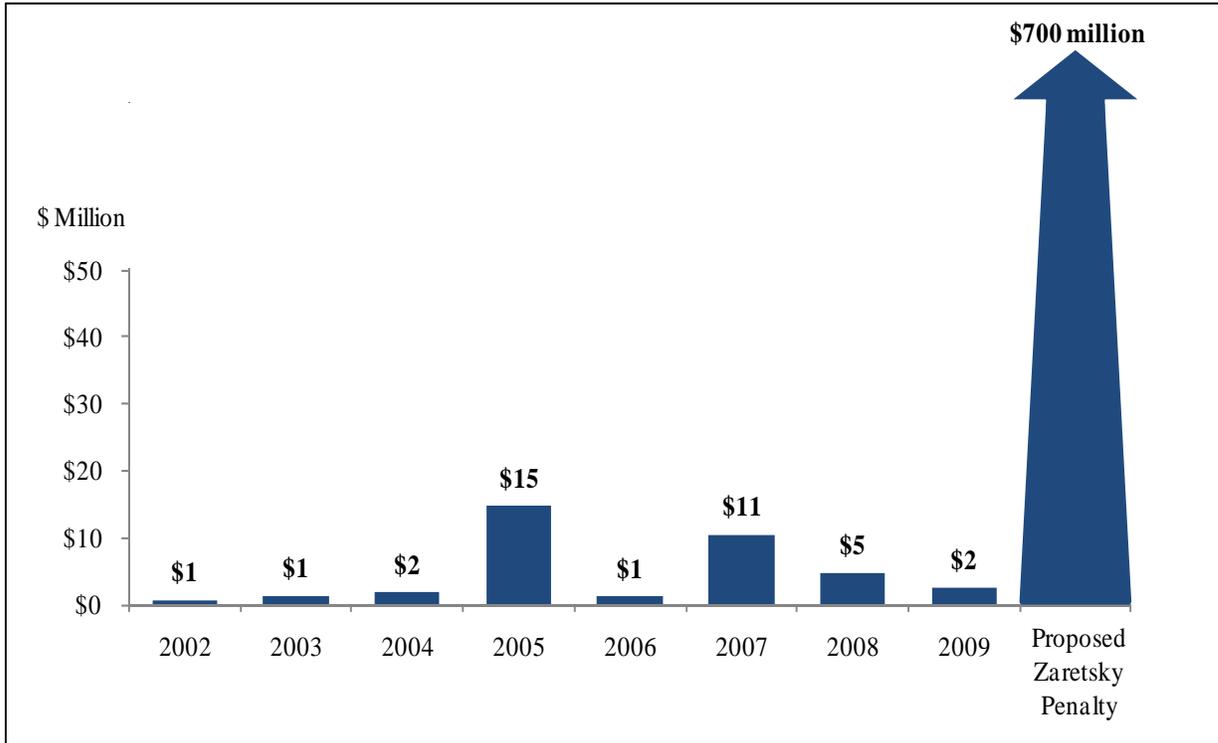
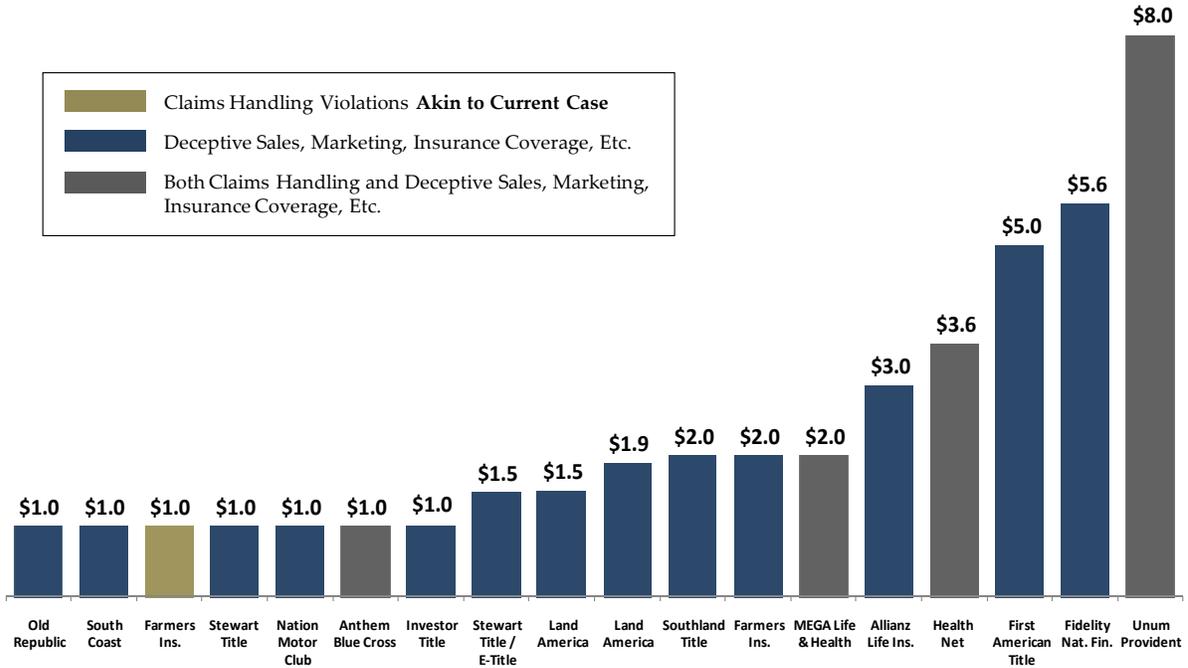


Figure 3 presents the 18 penalties over \$1,000,000 imposed by the CDI on any type of insurer since 2000. The average of these penalties was \$2.4 million. The largest penalty was \$8 million, imposed on Unum Provident. That case involved halting disability income benefits; and the harm in that case on its face was far greater than the harm in the current matter. Yet, despite this difference in harm, CDI's expert suggests a penalty as much as *one hundred times* higher should be imposed in this case.

Figure 3: Proposed Penalties For PacifiCare Far Exceed Every Other Penalty Imposed By CDI Since 2000

Published Penalties of \$1 Million Or More (amounts in millions)

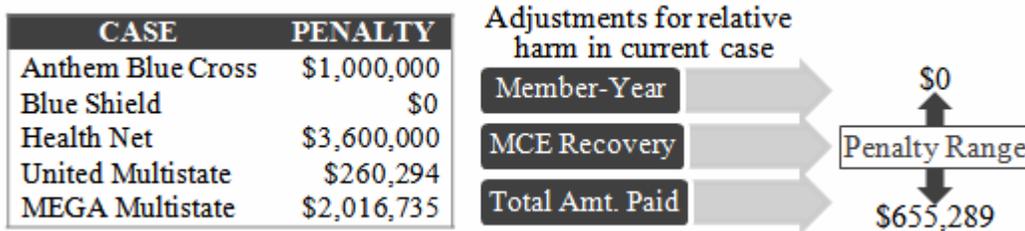


Based on historical penalties involving health care companies, the penalty in this case should be between \$0 and \$655,289. I arrived at this range through an analysis of the penalties that CDI imposed in the five cases it has pursued against health insurers since 2000. Based on that information, I inferred what penalty CDI should impose in this case, if it were to follow its own precedent. Three of the penalties arose out of market conduct examinations by CDI itself: Anthem Blue Cross, Blue Shield of California, and Health Net. Two of the penalties arose out of multistate settlements: United and MEGA.

To determine what historical penalties imply for the current case, I applied the principle that penalties should be proportional to harm, i.e. apply a standard of reasonable proportionality. Thus, if a past case caused twice as much harm as the current case, then the penalty should be twice as large; if it caused half as much harm as the current case, then the penalty should be half as large. To implement this, I needed to normalize, or scale, the historical penalties to reflect differences between those cases and the current one regarding: 1) number of affected members and the length of the violation periods; 2) the dollar recoveries from the insurers; and 3) the total amounts paid by insurers.

Figure 4 shows this process in graphical form. Details of these calculations are in Appendix E.

Figure 4: Appropriate Penalty, Based on Historical Cases



The validity of my approach depends on the accuracy of the measures of harm that I used to scale past penalties to the circumstances of the current case. If anything, the measures I used understate the harm in past cases relative to the current case. Anthem Blue Cross, Blue Shield, and Health Net involved not only claims-handling violations (as in the current case) but also far more serious allegations around improper rescissions -- that is, an improper termination of a member's policy, sometimes exposing them to liability for claims that they thought had already been paid. The MEGA Multistate case involved not only claims-handling violations (as in the current case), but also failures to disclose financial arrangements with the insurer's affiliates that were allegedly being used deceptively to enrich the insurer's management at consumers' expense.

The closest of the five past cases to the current case is United Multistate, in which the allegations were limited to claims-handling issues. The key areas of concern highlighted by the Lead Regulators in the Settlement Agreement most closely resembled the allegations in this matter. The time period covered by the settlement overlaps with the examination period in this case as do the parties involved. Adjusted to the circumstances of the current case, the penalty imposed in the United Multistate case implies a penalty in this case of \$182,949.

The fact that the current case involves a larger number of alleged violations than prior cases is not inconsistent with this conclusion. The current case is the only one to base its allegations on an analysis of an entire population of claims; prior cases all based their allegations on analyses of samples of claims. The fact that the samples were, by construction, much smaller than the populations of claims from which they were taken necessarily implies that a smaller number of violations would be found. The number of alleged violations taken in isolation, moreover, is not the measure, nor should it be the measure, for penalties under theories of economic deterrence.

IV. DR. ZARETSKY MISAPPLIES WELL ESTABLISHED ECONOMIC PRINCIPLES

Dr. Zaretsky misapplies well-established economic principles in three ways:

- Dr. Zaretsky's opinion that penalties should be proportional to the gain of the violator is inconsistent with the economic theory of deterrence and is logically flawed.
- Even if Dr. Zaretsky's theoretical analysis were correct, his estimate of the purported "gain" is not.
- Dr. Zaretsky's use of United's market value and the fact that PacifiCare took actions to minimize costs and increase profits, combined with the after-the-fact analysis of the soundness of micro-level business decisions to determine penalties, has no basis in economic principles.

A. Penalties Should Not Be Proportional To Gain

Dr. Zaretsky's opinion that "To achieve a deterrent effect, the minimum fine must conform to the following equation, $f > g/p$,"¹⁵ where g represents the gain to the violator and p represents the probability of detection, is inconsistent with the economic theory of deterrence and is incorrect. For the reason discussed above, fines based on gains are not in consumers' best interest (except in those instances where the harm exactly equals the gain).

B. Even If Dr. Zaretsky's Theoretical Analysis Were Correct, His Estimate Of The Purported "Gain" Is Not

Even if Dr. Zaretsky's opinions about the economic theory of deterrence were correct, his estimate of the gains to PLHIC from the alleged violations is unsupported by either the record or economic analysis. Dr. Zaretsky assumes that United expected \$70 million in gains from the integration of all of PacifiCare. Even if this assumption were correct, \$70 million is not a reasonable estimate of the gains to PLHIC from the alleged claims-handling violations.

For \$70 million to be a reasonable estimate, it would have to be true that *all* of the gains from integration were causally linked to the alleged violations -- in other words, that *none* of the gains would have been achieved in the absence of the alleged violations. This is unsupported by either the record or Dr. Zaretsky's analysis. Significantly, Dr. Zaretsky nowhere mentions, much less explains, how, for example, the alleged failure to send written acknowledgment letters, include certain form language in EOBs and EOPs, and pay claims after thirty days caused PacifiCare to gain anything.

Indeed, \$70 million could not be a reasonable estimate of the gains to PLHIC, the entity that is subject to CDI regulation. PacifiCare has numerous other subsidiaries -- and customers -- both in California and in other states that are not the subject of this action. If Dr. Zaretsky's estimate of \$70 million in gains were apportioned on the basis of

¹⁵ Pre-filed direct testimony of Dr. Zaretsky, p. 9, lines 26-8.

membership, only 5.8 percent of the gains, or \$4.1 million, would be attributable to PLHIC.¹⁶

C. United's Market Value Is Irrelevant

According to the theory of deterrence, neither fines nor penalties should depend on the resources of the violator. Professor Becker's original article makes this point directly: "optimal fines [d]epend only on the marginal harm and cost and not on the economic positions of offenders."¹⁷ Despite the absence of support for this approach anywhere in economics, Dr. Zaretsky embraces it without any explanation when he accepted the assumption provided to him by Counsel that "penalties should be large enough to hurt."¹⁸ This approach conflicts with economic principles and is not a reasonable basis to form an expert economic opinion about appropriate penalties.

Further, to the extent that the law arguably permits a regulatory proceeding to consider a regulated entity's market value, it should consider the value of the license holder, not the value of the license holder's parent. To do otherwise would give companies an incentive to spin off regulated entities even when it would be economically inefficient for them to do so.

D. Efforts At Maximizing Profits Do Not Justify Penalties Except In Specific Circumstances

Penalties should not depend on the fact that a firm took actions to maximize profits, except insofar as such actions are designed to reduce the probability of detection. Otherwise, firms would be punished for reducing costs and improving productive efficiency. An important goal of insurance regulation is the establishment of robust markets which depend upon profitability. Indeed, reducing costs and increasing profitability are hallmarks of a well run company and benefit consumers by allowing companies like PacifiCare to innovate, provide expanded services and offer products at lower cost. According to economic principles, if such actions do not affect the probability of detection, then they are not relevant to the determination of penalties.

Despite these principles of economics, Dr. Zaretsky -- without any explanation -- embraces the assumption provided to him by Counsel that "actions taken or omitted to augment profit represent an enhanced degree of culpability."¹⁹ This approach conflicts with economic principles and is not a reasonable basis to form an expert economic opinion about appropriate penalties.

¹⁶ As of the time of the acquisition, PLHIC had 148,428 of PacifiCare's 2,546,230 commercial members. (exhibits 5284 and 5369).

¹⁷ Becker, p. 195.

¹⁸ Pre-filed direct testimony of Dr. Zaretsky, p. 13, lines 18-26.

¹⁹ Id., p. 19, lines 21-24.

E. Economic Theory Does Not Support After-The-Fact Analysis Of Business Decisions As A Basis For Penalties

Though CDI's experts criticized certain decisions of the company relating to the integration of PacifiCare and United, such after-the-fact analysis has no bearing on either harm or gain. Such analysis could in theory form the basis for an increased penalty if it provided evidence that the firm was seeking to cover up the harm that it caused -- that is, seeking to reduce its probability of detection. However, nothing in Dr. Zaretsky's or Mr. Boeving's reports suggest that PacifiCare engaged in any effort to evade detection in this case. Indeed, as discussed above, there is substantial evidence that the decisions of United's and PacifiCare's management *increased* the probability of detection and so should lead to a *reduced* penalty, or to no penalty at all.

In any event, modern scholarship (at both ends of the political spectrum) argues against regulatory review of this sort in favor of "incentive" regulation. Incentive regulation can be defined as the use of rules that encourage regulated firms to achieve the desired goals by granting them discretion. The motivation behind this presumption is that firms have better information than regulators on production technology and consumers' preferences. Incentive regulation is therefore the best way to induce firms to employ their superior knowledge in the broader social interest.²⁰

V. BECAUSE CDI BECAME "CAPTIVE" TO PROVIDER INFLUENCE, DEFERENCE IS NOT APPROPRIATE

While regulations seek to protect doctors and hospitals, the interests of consumers remain primary. According to Robert W. Klein, who served as the director of research at the NAIC, "the goal of [insurance] regulation should be to protect consumers and promote the public interest."²¹ The guidelines in the NAIC Market Regulation Handbook concur that "remediation of harm to impacted consumers and preventing future harm to consumers are primary goals."²² Finally, the "number one priority" listed on the overview page of CDI's website is "protection of consumers."²³ This emphasis on consumer protection is important because the interests of consumers conflict with providers in key ways.

It is to be expected that a regulator would engage in substantial communications with providers to obtain information about claims-handling issues within the regulator's jurisdiction. However, when the regulator aligns itself with providers, engages in issues outside its jurisdiction and allows providers to guide its actions, regulation does not serve

²⁰ David E.M. Sappington, Designing Incentive Regulation, Review of Industrial Organization Vol. 9 (1994), p. 246-7. See also, Cass Sunstein, Remaking Regulation, The American Prospect, September 24, 1990, and Stephen Breyer, Regulation and Its Reform, Harvard University Press (1982), pp. 185-6.

²¹ Harold D. Skipper, Jr. and Robert W. Klein, Insurance Regulation in the Public Interest: The Path Toward Solvent, Competitive Markets, The Geneva Papers on Risk and Insurance, Vol. 25 No. 4 (October 2000), p. 487.

²² NAIC Market Regulation Handbook, Volume 1 (May 2009), p. 11.

²³ <http://insurance.ca.gov/0500-about-us/>.

consumers' best interests. This situation is known as “regulatory capture” under well-established and widely-accepted economic principles.²⁴ In such a situation, the decision-maker should not grant deference to the regulator's position.

In my opinion, this matter reflects a serious case of regulatory capture. There is substantial evidence that, in this case, CDI became captive to doctors and hospitals and, as a result, was used to promote their private financial interests. In his 2009 Brookings Institution book, Professor Robert Klein (who previously served as the director of research for the NAIC) cautions that capture can be a problem in insurance regulation. According to him:

The political economy of regulation is characterized by groups vying for policies that favor their economic interests. Some groups may be relatively small but have relatively substantial and concentrated economic interests. They are more likely to prevail on issues that are opaque and not salient to the majority of consumers.²⁵

This literature warns about the conditions under which small, homogeneous, well-organized interest groups can misuse the regulatory process: the costs of mobilizing group(s) to engage in political action are small; the benefits of legislation are concentrated and costs are diffuse; regulatory policymaking is not publicly observable; and the legal issues are complex, so voters cannot easily determine whether legislation is in their interest. These factors are all relevant in this case.

In particular, Justice Elena Kagan states that capture is especially problematic when interaction between regulators and interest groups take place in "informal and nontransparent ways that [r]aise concerns about inequalities of interest group access."²⁶ As I discuss below, the lack of transparency in CDI's communications with the CMA and other providers enhance my conclusion that this action is not serving consumers' interests.

CDI acknowledges that this case is about actions affecting providers. Joel Laucher, who served as the chief of the market conduct division of CDI at the time of the examination, testified that he agreed with Towanda David, the Senior Insurance Compliance Officer who conducted the examination, that it was "focused on provider issues."²⁷ That fact alone is not determinative. However, other evidence leads me to conclude that capture is a problem.

²⁴ According to Justice Elena Kagan, "Although the [capture] thesis often was stated too crudely, few could argue with its basic insight - that well-organized groups had the potential to exercise disproportionate influence over agency policymaking by virtue of the resources they commanded, the information they possessed, and the long-term relations they maintained with agency officials." Elena Kagan, Presidential Administration, Harvard Law Review (2001) Vol. 114, p. 2265. See also Cass Sunstein, Remaking Regulation, The American Prospect, September 24, 1990.

²⁵ Robert Klein, The Insurance Industry and Its Regulation: An Overview, Chapter 3 (p. 30-1), in Martin Grace and Robert Klein, eds. (2009), The Future of Insurance Regulation in the United States, Washington: Brookings Institution.

²⁶ Elena Kagan, Presidential Administration, Harvard Law Review (2001) Vol. 114, p. 2267.

²⁷ Testimony of Joel Laucher, 11/3/10, p. 13188.

CDI apparently based key decisions about the scope and extent of the examination on unsubstantiated allegations by providers about PacifiCare's and United's behavior. As it turns out, the magnitude of these allegations were vastly overstated. Aileen Wetzel (an associate director of the California Medical Association (CMA)) testified that she had told CDI that there were "thousands" of complaints about United and PacifiCare.²⁸ Jodi Black, another associate director of the CMA who communicated with CDI, testified that the CMA had taken "thousands of calls" from physicians relating to their concerns about the merger between United and PacifiCare.²⁹ However, when I examined the CMA call log data, there were *only 237 entries in total* in the CMA's log of calls regarding United and PacifiCare from March of 2005 through June of 2009. Furthermore, most of the 237 calls *were not complaints at all*. Only 25 percent of the 237 calls were complaints about contracts and claims processing, the issues at the heart of this matter. Appendix F provides additional detail of my analysis.

Second, CDI engaged in communications with the CMA and other providers in which CDI officials agreed to promote provider interests, even when it might harm consumers or violate CDI's own internal policies. The most troubling example of this from the perspective of public policy is CDI's discussions with providers about contract terms between United/PacifiCare and physicians, even though the CDI has no jurisdiction over this issue, which fundamentally changed the balance of power in an otherwise arms length transaction between private parties.³⁰ Ms. Wetzel testified that CDI and CMA representatives discussed specific PacifiCare/United contract terms.³¹ Similarly, the agenda for an April 19, 2007 meeting between Mr. Laucher and the University of California Health System regarding United and PacifiCare contained "contract issues" as one of the five major topics to be discussed.³² CDI's interest in prices paid to providers was confirmed by Sue Berkel, the Senior Vice President of United for Operations Integration, who testified that CDI raised the concern that the rates being offered by United and PacifiCare were "unfair."³³

Third, communications between CDI officials and the CMA show an undue level of influence by CMA officials on CDI's decisions in this matter. Indeed, CMA appears to have coordinated with CDI to increase the number of reported provider complaints, which helped form the basis for this proceeding against PacifiCare. A CDI attorney sent an email to Ms. Wetzel in April of 2007 telling her to "feel free to have your members use the RFA/complaint process operated by the CDI and the DMHC's as well. The more numbers racked up, the better."³⁴ My analysis of the CDI's complaint data, reported in Figure 5, shows that the number of complaints from providers around the time of these communications increased substantially. However, at the same time, the proportion of

²⁸ Testimony of Aileen Wetzel, 2/17/11, p. 16810.

²⁹ Testimony of Jodi Black, 1/5/10, p. 1249.

³⁰ Price negotiations between health plans and physicians are generally considered to be highly confidential. Indeed, sharing of price information by either plans or physicians, even with public officials, is regulated under the antitrust laws, in order to insure that prices are competitively determined.

³¹ Testimony of Aileen Wetzel, 2/17/11, p. 16815-16816.

³² CDI00254868-254869

³³ Testimony of Sue Berkel, 6/9/10, pp. 7566-7.

³⁴ CMA production, CMA 0038.

provider complaints in which CDI's own staff concluded no violation of law occurred increased far more, suggesting that a disproportionate share of these complaints were not legitimate. Details of this analysis are in Appendix D.

Figure 5: Provider Complaints To CDI With And Without Associated Violations (June 2006 - December 2007)

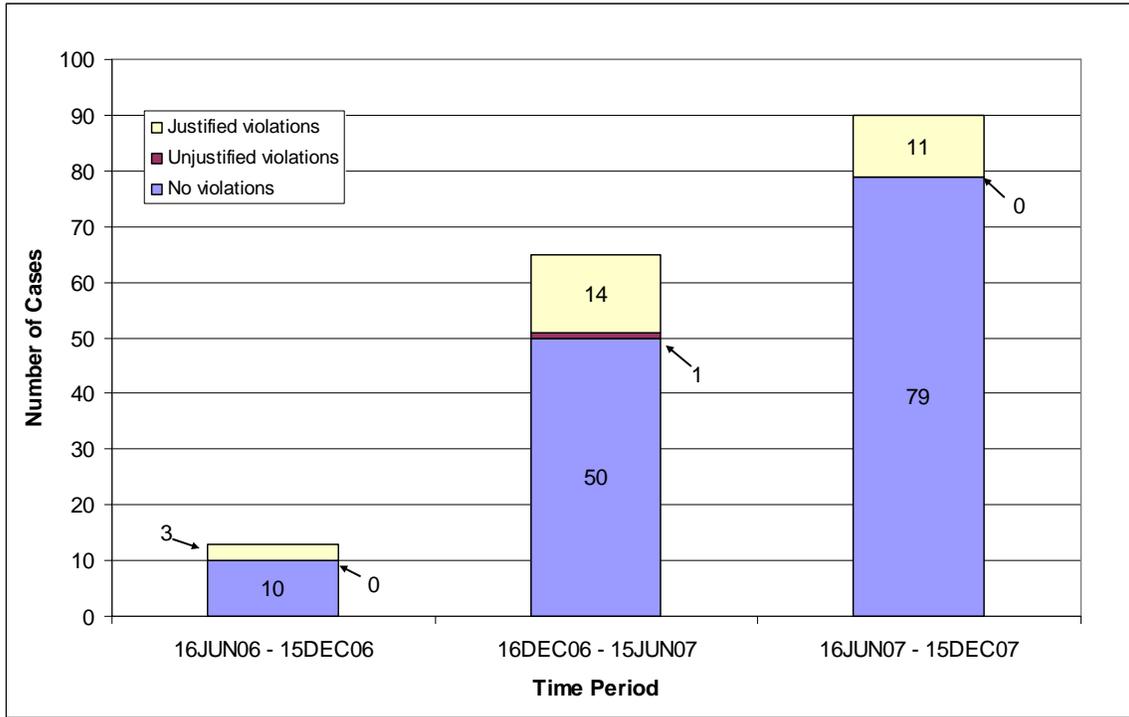


Figure 6 presents other examples of communications between the CMA and CDI consistent with regulatory capture. For example, in an email exchange with Catherine Hanson, Andrea Rosen, counsel for CDI, said “as a result of your teachings and influence, I have gotten the CDI to expand the scope [of the investigation].” In another email, Ms. Rosen asked Ms. Wetzel if she wanted CDI to require that complaining physicians go through the formal CDI process, even though this process was mandatory according to CDI's CSB Health Unit Procedures Manual. Indeed, it is questionable whether *any* use of provider complaints as a basis for a targeted examination is consistent with CDI's internal procedures, as the CDI's Market Conduct Examination Procedures Manual makes no mention of provider issues in its section on Insurance Company Selection.³⁵ Finally, Ms. Black sent an email to the attorneys for CDI describing CDI's allegations against PacifiCare as a "gold mine" of violations. This is consistent with the hypothesis that the CMA is using this proceeding to weaken PacifiCare's bargaining position with physicians rather than address claims processing issues.

³⁵ Ex. 5407, Sec. 405.

Figure 6: Communications Between CDI And CMA Consistent With Regulatory Capture

Location	Documentary Evidence
CMA0007	"more money in the state treasury doesn't really help your doctors, does it?" [email from Andrea Rosen, CDI to Aileen Wetzel, CMA]
CMA0014	"as a result of your teachings and influence, I have gotten the CDI to expand the scope [of the investigation]" [email from Andrea Rosen, CDI to Catherine Hanson, CMA]
CMA0038	"I am confident that you all at CMA will be pleased with the direction we are heading" [email from Andrea Rosen, CDI to Aileen Wetzel, CMA]
CMA0050	"did you want their [physician] complaints to go through the formal provider complaint process?" [asked by Andrea Rosen of CMA despite the fact that complaints had to go through this process according to the CDI CSB Health Unit Procedures Manual, Ex5085, p. xxviii]
Ex5512	"Wow! Looks like you uncovered a gold mine of additional violations." [email from Jodi Black, CMA to Michael Strumwasser and Andrea Rosen, CDI]

VI. THIS ACTION'S UNDUE FOCUS ON PROVIDER INTERESTS HARMS CONSUMERS

Misuse of the regulatory process by health care providers in this case has substantive implications for consumers as well as procedural implications. Keeping health insurance costs down has become one of the most pressing economic and social issues in this country. Providers' use of insurance regulation to weaken the bargaining power of insurers, as they have sought to do with United and PacifiCare in this matter, enhances providers' market power and leads to higher prices and insurance premiums for consumers. According to recent peer-reviewed research, this is an especially serious problem in California.

Higher health costs are a big problem for consumers. High costs lead to both higher insurance contributions and rising out-of-pocket spending. The combined employee direct cost of health care *more than doubled* from \$3,635 in 2002 to \$8,008 in 2011.³⁶ Increases in the costs that employers bear ultimately fall on consumers as well.³⁷ From 2002 to 2011, the total cost of health care for a family of four with employer-sponsored

³⁶ Source: Milliman Medical Index, 2006 and 2011 Reports.

³⁷ In a recent statement, Insurance Commissioner Jones agrees that California consumers ultimately foot the bill for rising insurance costs. California Department of Insurance, Insurance Commissioner Jones Files to Intervene in a Whistleblower Lawsuit Against Sutter Hospitals, April 13, 2011.

preferred-provider insurance has *more than doubled* -- from \$9,235 to \$19,363.³⁸ This represents an increasing percentage of the median household's total income. From 2002 to 2009 (the last year for which median household income is available), the share of income going to health spending rose from 22 to 34 percent.³⁹

A 2010 study published in the peer-reviewed journal *Health Affairs* reports findings of regulatory capture in the California health care market that bear directly on this matter.⁴⁰ First, the study reports how doctors and hospitals have been able to build market power vis-à-vis health plans in order to raise the prices they charge health insurance companies significantly above the competitive level. According to the authors:

"The shift in who holds the upper hand in negotiating payments -- once held by health insurance companies but now resting with health care providers -- has had a major impact on California premium trends."⁴¹

This finding shows both the link between provider market power and rising prices paid by regulated health insurance companies in California and how these higher prices have resulted in higher health insurance costs to consumers. Second, and of direct relevance to this matter, the study describes the current insurance regulatory environment in California and how it has evolved to enhance providers' market power, which they use to raise prices. Specifically, the study reports that both "health plan *and provider representatives* also point to a regulatory environment in the aftermath of the managed care backlash that appears to favor providers in negotiations [*italics added*]."⁴²

These costs to consumers of growing provider market power, enhanced by their ability to manipulate the regulatory environment, are detailed in other recent published research. According to a 2008 study published in the peer-reviewed *International Journal of Health Care Finance and Economics*, lack of competition in markets for physician services in California has led to significantly higher prices.⁴³ The study concluded that the balance of market power between health plans and physicians favors physicians, and that the weakening of health plans' ability to negotiate ultimately feeds back to

³⁸ Source: Milliman Medical Index, 2006 and 2011 Reports; US Census Bureau, Current Population Survey, Annual Social and Economic Supplement, <http://www.census.gov/hhes/www/income/data/statemedian/index.html>

³⁹ Source: Milliman Medical Index, 2006 and 2011 Reports; US Census Bureau, Current Population Survey, Annual Social and Economic Supplement, <http://www.census.gov/hhes/www/income/data/statemedian/index.html>

⁴⁰ Robert Berenson, Paul Ginsburg, and Nicole Kemper, Unchecked Provider Clout in California Foreshadows Challenges to Health Reform, *Health Affairs* (2010).

⁴¹ Robert Berenson, Paul Ginsburg, and Nicole Kemper, Unchecked Provider Clout in California Foreshadows Challenges to Health Reform, *Health Affairs* (2010) 4: p. 704.

⁴² Robert Berenson, Paul Ginsburg, and Nicole Kemper, Unchecked Provider Clout in California Foreshadows Challenges to Health Reform, *Health Affairs* (2010) 4: p. 701.

⁴³ John Schneider et al., The Effect of Physician and Health Plan Market Concentration on Prices in Commercial Health Insurance Markets, *International Journal of Health Care Finance and Economics* (2008) 8, pp. 13-26.

consumers. Recent Regional Markets Issue Briefs by the California Health Care Foundation conclude that "Like much of northern California, Sacramento is dominated by powerful hospital systems with significant negotiating leverage over health plans"⁴⁴ and that in the Bay Area, "health plans struggle to contain costs" and UCSF is "perceived to have leverage in certain geographic and service areas."⁴⁵

A recent analysis by the *Los Angeles Times* suggests that hospital prices are much higher in Northern than in Southern California, and that this is due to the unusual market power of a handful of provider networks.⁴⁶ In a recent presentation to the San Francisco Board of Supervisors, the Pacific Business Group on Health (the country's leading non-profit coalition of employers that seeks to improve the quality and value of health care for its members' employees) emphasized the link between provider market power and the high costs of healthcare in Northern California.⁴⁷

The implications of this literature to consumers is clear and disturbing. Providers have been able to increase their market power in California in a variety of ways including influencing the health insurance regulation structure and process to weaken health insurance negotiating leverage in order to raise their prices to health plans. Health plans, as a result, have been forced to raise health insurance premiums. This explanation and model as the underlying cause of rising health insurance premium levels in California was recently confirmed by a study conducted by the California Health Care Foundation. That study concluded that higher prices for health care services -- *not* increases in administrative costs or insurer profits -- drive premium growth in California.⁴⁸

⁴⁴ California Health Care Foundation, Sacramento: Powerful Hospital Systems Dominate a Stable Market, Regional Markets Issue Brief (July 2009), p.1.

⁴⁵ California Health Care Foundation, San Francisco Bay Area: Downturn Stresses Historically Stable Safety Net, Regional Markets Issue Brief (July 2009), p. 4.

⁴⁶ Duke Helfand, Hospital Stays Cost More in Northern California than Southern California, *Los Angeles Times*, March 6, 2011.

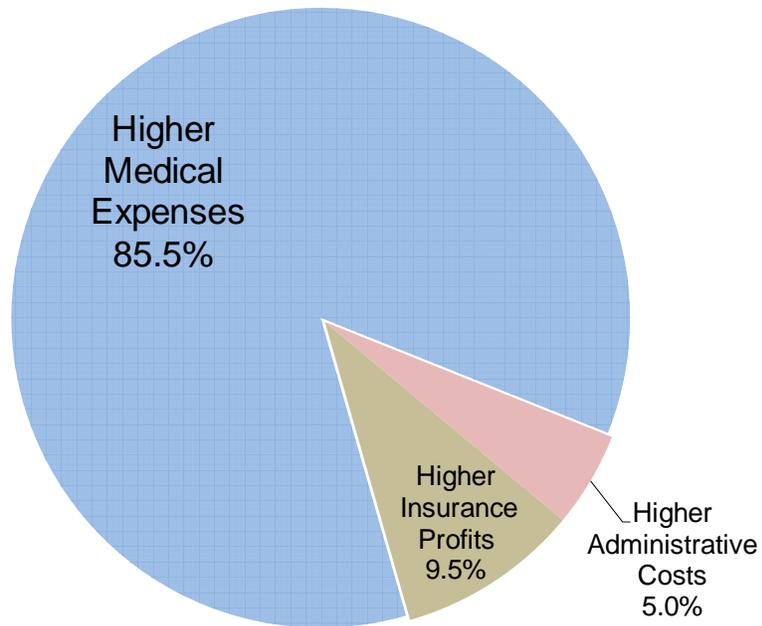
⁴⁷ The Pacific Business Group on Health, The Effects of Market Consolidation on Hospital Costs and Quality In the City and The Region, Presentation to the San Francisco Board of Supervisors, April 28, 2011.

⁴⁸ California Health Care Foundation, How Much is Too Much? An Analysis of Health Plan Profits and Administrative Costs in California, November 2008.

Figure 7 summarizes the results of that study. According to the analysis, premiums per commercially-insured person in California increased about 10.6 percent per year over the study period. When researchers broke down the increase into its component parts, they found that the essentially all of it was due to the rising cost of health services, such as physician fees and hospital charges. Higher medical expenses explained 85.5 percent of the increase; higher administrative costs explained 5 percent; and higher insurance profits explained 9.5 percent.

Figure 7: Rising Premiums Due To Spending On Health Services -- NOT Insurer Profits
Causes Of Rising Premiums In California, 2002-6

Per Member	2002	2006
Medical Expenses	\$2,124	\$3,138
Admin Costs	\$190	\$249
Insurer Profits	\$65	\$178



This concludes my report.

APPENDIX A

Appendix A

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David S. and Ann M. Barlow Professor in Management, Graduate School of Business,
Stanford University, 2007-10
Visiting Professor, Harvard Law School, 2007
Senior Fellow, Hoover Institution, Stanford University, 2006-
Professor, by courtesy, Stanford Law School, 2004-2009
Professor, Graduate School of Business, Stanford University, 2003-
Visiting Associate Professor, Wharton School, University of Pennsylvania, 2002-03
Associate Professor, Graduate School of Business, Stanford University, 1998-2003
Assistant Professor, Graduate School of Business, Stanford University, 1994-98

Awards and Fellowships:

Affiliate, Stanford Center on Longevity, 2008-
Health Care Research Award, National Institute for Health Care Management Foundation, 2003
Fellow, Center for Advanced Study in the Behavioral Sciences, 2003-04
Graduate School of Business Trust Faculty Fellow, 2000-01
Affiliate, Center for Social Innovation, Stanford Graduate School of Business, 2000-
Research Associate, National Bureau of Economic Research, 1999-
Public Policy Advising Award, Stanford University, 1998
Kenneth J. Arrow Award for Best Paper in Health Economics, International Health Economics Association, 1997
Affiliate, Center for Health Policy, Stanford University, 1997-
Class of 1969 Faculty Scholar, Stanford Graduate School of Business, 1997-98
National Fellow, Hoover Institution, 1997-98
John M. Olin Faculty Fellow, 1996-97
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Academic Publications:

- “The Effect of Tax Preferences on Health Spending” with John F. Cogan and R. Glenn Hubbard, *National Tax Journal*, forthcoming.
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“The Roberts Enterprise Development Fund,” with Lauren Dutton, Jed Emerson, and Melinda Tuan, Stanford GSB (1998).

“Echelon and the Home Automation Standard,” with David Baron, Keith Krehbiel, Erik Johnson, and Michael Ting, Stanford GSB (1997).

“The European Union Carbon Tax,” with David Baron and Daniel Diermeier, Stanford GSB (1996).

Unpublished reports:

“Cost Shifting in California Hospitals: What is the Effect on Private Payers?” for the California Foundation for Commerce and Education (2007).

“The Determinants of the Cost of Medical Liability Insurance,” for Physician Insurers Association of America (2006).

“The Effects of Behavioral Health Interventions on Health Care Costs,” for the Foundation for Better Health (2005).

“The Effects of Pharmaceutical Price Controls on the Cost and Quality of Medical Care: A Review of the Empirical Literature,” for Pharmaceutical Research and Manufacturers of America (2004).

“The Impact of the Balanced Budget Act of 1997 on Skilled Nursing Care in California,” with Chris Afendulis, Jeffrey Geppert, and Owen Kearney, for the California Health Care Foundation (2003).

Referee/reviewer:

American Cancer Society; American Economic Review; Health Affairs; Journal of Health Economics; Journal of Health Politics, Policy, and Law; Journal of Law, Economics, and Organization; Journal of Law and Economics; Journal of Legal Studies; Journal of Political Economy; National Science Foundation; National Institutes of Health; RAND Journal of Economics; Quarterly Journal of Economics

APPENDIX B

Appendix B

As part of my work on this case, I relied upon the following categories of materials:

- Market conduct examination reports and legal documents in this matter.
- Market conduct examination reports, legal documents, and/or settlement documents in the five cases CDI has pursued against health insurers since 2000.
- The CDI Website.
- NAIC Market Conduct Handbook and annual NAIC filings of various insurers.
- Reports of Dr. Zaretsky and Mr. Boeving.
- Testimony and exhibits in this matter.
- Scholarly research on the economics of deterrence, public enforcement of law, health policy, regulatory capture, and insurance regulation.
- News articles and other publicly-available information on health policy and health care costs.
- Relevant sections of the California Insurance Code and the California Code of Regulations.
- Electronic files constituting the CDI claims database.
- The call log from the California Medical Association.
- The Undertakings, reports filed with the CDI as part of the Undertakings, and other documents associated with the United/PacifiCare merger.
- Information on Independent Medical Reviews from PacifiCare.

APPENDIX C

Appendix C

Appendix C presents the basis for my conclusions about harm from each of the six categories of violations referenced in my report. I discuss each category of violations below:

1. *Omission of form language in EOP.* No harm resulted from PacifiCare's alleged failure to include language on EOPs until June 15, 2007, informing providers of the right to seek review of contested or denied claims by CDI. Any harm that could have resulted from providers' unawareness of their rights would be reflected in fewer justified complaints by providers pre-June 15, 2007, as compared to post-June 15, 2007.

To investigate this issue, I analyzed the three files in the CDI complaint data base described in Appendix D. I found that there were 14 cases with justified complaints by providers opened from December 16, 2006 through June 15, 2007, and 11 cases with justified complaints by providers opened from June 16, 2007 through December 15, 2007. *There were actually more cases with justified complaints in the period before the EOP language was included.*

One possible concern with this analysis is that the number of PacifiCare members was declining over this period, so the number of possible encounters between providers and PacifiCare that might have given rise to a complaint was itself declining. To account for this possibility, I calculated the number of members in each of the six month periods in question based on PacifiCare's 2006 and 2007 NAIC filings.¹ I found that the number of complaints per thousand members rose slightly from 0.070 to 0.077,² but that this rise was not statistically significant, that is, it was likely to have occurred by chance.³ This reinforces my conclusion that there is no evidence of harm from the alleged failure to include EOP language notifying providers of their rights.

2. *Omission of form language in EOB.* No harm resulted from PacifiCare's alleged failure to include language on EOBs until June 15, 2007 informing members of the right to seek an independent medical review (IMR). Any harm that could have resulted from members' unawareness of their rights would be reflected in fewer IMR requests pre-June 15, 2007, as compared to post-June 15, 2007.

To investigate this issue, I counted the number of IMRs requested, the number of IMRs that CDI accepted as valid, and the number of accepted IMRs in which PacifiCare's initial

¹ The average number of members in the early period was 199,743; the average number of members in the late period was 142,302.

² $0.070 = 14 / 199.743$; $0.077 = 11 / 142.302$.

³ Because 14 complaints were observed in a sample of 199,743 members and 11 complaints were observed in a sample of 142,302 members, an hypothesis test would reject that the proportions were equal at a 5

percent level of significance when $Z = \frac{11}{142,302} - \frac{14}{199,743} / \sqrt{\frac{\left(\frac{25}{342,045}\right) \times \left(1 - \frac{25}{342,045}\right) \times (342,045)}{199,743 \times 142,302}}$ was

at least 1.96. Because $Z = 0.243$, the hypothesis test fails to reject that the complaints per member in the two periods were the same.

decision was overturned. I counted the number of requests, acceptances, and overturns in the two six-month periods prior to June 15, 2007 and the two periods after June 15, 2007. Appendix Table C1 presents the results of my analysis.

Appendix Table C1: Number of IMRs Opened Before and After Revised EOB Form Language Was Included

IMR Open Date	Before or After Revised EOB Form Language Included?	Number of IMRs Requested	Number of IMRs Accepted by CDI as Valid IMR Requests	Number of IMRs in which PacifiCare's Decision Was Overturned
6/16/06 - 12/15/06	Before	2	0	0
12/16/06 - 6/15/07	Before	11	6	3
6/16/07 - 12/15/07	After	2	1	0
12/16/07 - 6/15/08	After	2	1	0

The fact that there were so many more IMRs requested pre-June 15, 2007, than post-June 15, 2007, reinforces my conclusion that there is no evidence of harm from the alleged failure to include EOB language notifying members of their IMR rights.

3. *No written provider acknowledgement letters within 15 days.* No harm resulted from PacifiCare's alleged failure to acknowledge receipt of claims via written acknowledgement letters. Providers and consumers were able to ascertain the status of their claims on the PacifiCare website and over the telephone, so the harm they suffered was the inconvenience having to use one of these modes rather than receive a printed letter sent by US mail. Dr. Zaretsky's opinion about "confusion" and theoretical "increased administrative costs" is inconsistent with the stated policy of the California Department of Managed Health Care, which I understand does not require health plans to proactively send a physical letter to providers or members.⁴

4. *Failure to retain copies of acknowledgement letters.* No harm resulted from PacifiCare's alleged failure to retain copies of acknowledgement letters. Claim status was recorded in PacifiCare's database, and so was as available to consumers and regulators as it would have been had PacifiCare printed a physical acknowledgement letter and kept it in a file.

5. *Failure to pay uncontested claims within 30 working days.* No harm resulted from failure to pay uncontested claims within 30 working days, for those claims in which PacifiCare voluntarily paid the statutory 10 percent interest required. The statutory 10 percent rate is far greater than the time value of money during the period when these violations were alleged to have occurred. At the time this case began in 2007, the FTB was charging individuals a penalty rate of only 6 percent on their unpaid income taxes -- four percentage points less than the statutory rate for late-paid health insurance claims.⁵

⁴ See Exhibit 5263.

⁵ <http://www.ftb.ca.gov/individuals/faq/ivr/617.shtml>.

Academic research supports the conclusion that the 10 percent rate includes sufficient compensation to late-paid providers for any increased administrative costs. According to a recent study in the peer-reviewed journal *Health Affairs*, business office expenses attributable to billing and insurance-related functions accounts for 2.1 to 4 percent of revenue for physicians and 1 percent of revenue for hospitals.⁶ Thus, even if late payment did result in increased administrative costs, these costs would be at most a tiny fraction of the associated revenues.

6. *Failure to pay interest on uncontested "late paid" claims.* According to CDI, PacifiCare allegedly failed to pay \$156,455 of interest on uncontested "late paid" claims, which I conclude is the maximum amount of harm resulted from these alleged violations. As discussed above, the statutory interest rate of 10 percent is much greater than the time value of money during the period when these violations were alleged to have occurred.

⁶ James Kahn et al., The Cost of Health Insurance Administration in California: Estimates for Insurers, Physicians, and Hospitals, *Health Affairs* (2005) Vol. 24, pp. 1629-39.

APPENDIX D

Appendix D

I analyzed three files from the CDI complaint data base: (1) a "cases" file that contains cases opened by CDI from December 19, 2005 to January 25, 2008 (CDI did not disclose the period covered by the database that they produced; I inferred that this was the period covered by the earliest and latest open dates); (2) a "sources" file that contains sources of complaints, with a variable that captures whether the complainant was a health care provider or another entity; and (3) a "violations" file that contains the violations that CDI alleges underlay each of the complaints, with a variable that captures whether the CDI determined each alleged violation constituted a "justified" complaint (10 CCR Sec. 2694).

I merged these three files together based on a common, unique case identifier. I classified each case as arising out of a justified violation in a manner that was designed to be as unfavorable to PacifiCare as possible. I counted a case as arising out of a justified violation if the case had any violation that CDI determined was justified -- even if, as was sometimes the case in the data base, the justified violation didn't have anything to do with the original complaint.

APPENDIX E

Appendix E

Appendix Figure E1 presents the details of my calculations to adjust historical penalties to the circumstances of the current case. Row 1 of the table presents the period in which the misconduct that was the basis for the penalty was alleged to have occurred. Row 2 presents the penalty that was imposed. Rows 3-5 present three different measures of the harm that the insurers were alleged to have caused. Row 3 reports the product of the number of members who were affected by the alleged misconduct and the number of years that the misconduct was alleged to have occurred. This yields the number of member-years who were affected. Row 4 reports the amount recovered as part of the market conduct exams underlying the penalty. This amount is missing for Anthem Blue Cross because the public version of the CDI market conduct exam did not report any recoveries; it is missing for the United Multistate and MEGA Multistate penalties because I was not able to find any recoveries for California consumers as a result of the market conduct exams underlying those penalties. Row 5 reports total amounts paid as part of the resolution of the Anthem Blue Cross and Health Net cases, equal to the sum of the amounts recovered as part of the market conduct exam plus additional amounts paid according to CDI press releases. I was not able to find any additional amounts paid as part of the resolution of the other three cases.

Rows 6-8 divide the penalty in row 2 by the three different measures of harm in rows 3-5, respectively. That yields the number of dollars of penalty imposed by CDI per unit of harm caused.

Rows 9-11 multiply the penalties per unit of harm in the five previous cases by the analogous measures of harm in the current case. This yields what the penalty in the current case should be according to CDI precedent, if penalties are to be proportional to harm. For example, according to membership counts from NAIC filings, the number of member-years affected in the current case is 166,317. If the penalty per member-year were to be \$1.06, as it was for Anthem Blue Cross, then the total penalty would be \$176,296, or \$1.06 times 166,317. If the penalty per member-year were to be \$3.93, as it was for Health Net, then the total penalty would be \$653,626, or \$3.93 times 166,317.

The range of penalties suggested by this approach is between \$0 and \$655,289.

Appendix Figure E1

	<u>Anthem Blue Cross</u>	<u>Blue Shield</u>	<u>Health Net</u>	<u>United Multistate</u>	<u>MEGA Multistate</u>	
1	Review Period ¹	1/1/04 - 2/28/06	6/1/04 - 5/31/08	12/1/03 - 2/29/08	8/27/04 - 8/26/07	1/1/00 - 12/31/04
2	Penalty ²	\$1,000,000	\$0	\$3,600,000	\$260,294	\$2,016,735
<u>Measures of Harm In Past Cases</u>						
3	Number of affected member-years ³	941,667	1,410,143	916,638	236,112	511,452
4	Amount recovered within MCE ⁴	*	\$1,036,114	\$1,224,500	*	*
5	Total amounts paid ⁵	\$14,000,000	*	\$22,624,500	*	*
<u>Penalty Per Unit of Harm In Past Cases</u>						
6	Penalty/member-year	\$1.06	\$0	\$3.93	\$1.10	\$3.94
7	Penalty/\$ MCE recovery	*	\$0	\$2.94	*	*
8	Penalty/\$ total amounts paid	\$0.07	*	\$0.16	*	*
<u>Implied Penalty In This Case</u>						
9	Based on number of affected member-years of:					
	166,317	\$176,296	\$0	\$653,626	\$182,949	\$655,289
10	Based on amount recovered within MCE of:					
	\$156,455	*	\$0	\$459,978	*	*
11	Based on total amounts paid of:					
	\$156,455	\$10,952	*	\$25,033	*	*

Notes: * = not available.

1. Although there is no formal review period relating to the United Multistate settlement, the settlement precludes participating regulators (including California) from imposing additional fines for the three years prior to the settlement's effective date of 8/27/07 (see paragraph C.11). Although there is no formal review period relating to the MEGA Multistate settlement, the settlement requires participating regulators (including California) to terminate examinations and investigations of the companies on matters set forth in pp. 27-8 of the multistate examination report, including the time frame of the examination, which is reported to be the five years preceding 12/31/04.

2. Penalty from the MEGA Multistate settlement is based on the penalty apportionment allocation in Attachment B to the settlement and NAIC annual statements.

3. Number of member-years from NAIC annual statements except for United Multistate, where number of affected member-years is from the Multistate settlement documents themselves.

4. Based on publicly-available documents.

5. Total amounts paid equals amount recovered within MCE plus additional amounts paid according to CDI press releases.

APPENDIX F

Appendix F

To determine what types of calls were in the CMA data, I categorized the calls into four groups: a complaint about contract or claims processing, a complaint about contract terms, a request for information, or something else. These categories are shown in the figure below. I classified calls into these groups in a manner that was designed to be as unfavorable to PacifiCare/United as possible. I counted every call as a complaint that had the words "concern", "complaint", or "problem" in the description field. I counted calls as requests for information if they didn't have any of these words in the description but did have the any of the words "question", "request", "update", "referral to [source]", "sent materials", "guidance", "assistance", or "clarification". Many calls didn't have a description; I counted these as something else. I distinguished between complaints about contract and claims processing and complaints about contract terms because the CDI doesn't have jurisdiction over contract terms, and in any event, physician dissatisfaction with contract terms is not one of the issues in this case.

**CMA “Complaint” Data – Reasons For Calls About PacifiCare-United
(May 2005 – June 2009)**

