Scope of Assignment

Within the context of Dr. Zaretsky's testimony:

I. According to economic principles, how should penalties be determined and what penalty, if any, is appropriate here?

II. What relevance, if any, do CDI's dealings with providers have in this case?

Summary of Opinions

I. According to economic principles, no penalty is appropriate in this case.

II. If the decision-maker determines that some penalty is appropriate, based on historical penalties, it should be between $0 and $655,289.

III. CDI's dealings with providers are relevant because they show that CDI became captive to their interests. Thus, the traditional deference to regulators should not be accorded here.

The Theory of Deterrence

harm

$$F = \frac{H}{P}$$

fine

Probability of detection

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

Restitution

Penalty paid to regulator in addition to restitution

Formula omits costs of enforcement, which should also be paid by the violator.

Optimal Deterrence

What is optimal deterrence?

- Fully addresses costs of harm.
- Balances costs and benefits of compliance.
- Requires notice.
  - Without notice, potential violators won't know what (not) to do.
  - More generally, lack of notice is bad for consumers.
    - Unpredictability in the regulatory process discourages both investment to improve compliance and future entry of new competitors.
    - Less investment and entry reduce competition.

CDI Concedes Importance of Notice

- Dr. Zaretsky concedes that notice of what constitutes non-compliant behavior is required.

  Q. So your analysis about the weighing the decision that United leadership made assumes that United had notice of the law, correct?
  A. Correct.
  Q. Assumes that United knew that the conduct at issue violated the law, correct?
  A. Yes, right. *[Tr. 18737:5-11]*

- CDI declined to allege violations for non-conforming EOBs and EOPs prior to when notice was given.

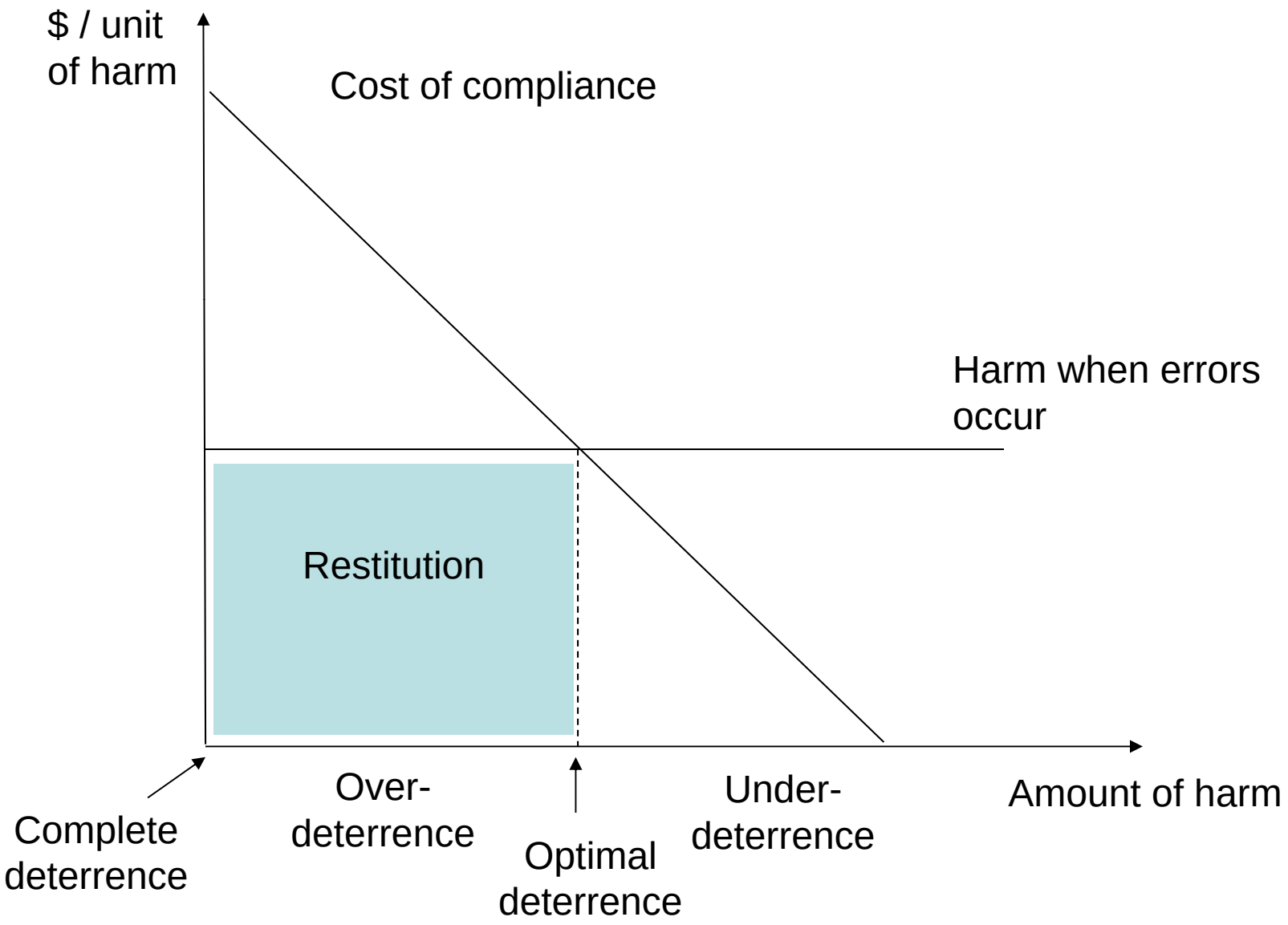
Complete Deterrence

What is complete deterrence?

- The avoidance of all error regardless of cost.
- Not attainable in large scale transactional operations.
- Not in consumers' interest because it doesn't balance the costs and benefits of compliance.
- No state regulator adopts this standard.[1]

Note: 1. Testimony of Dr. Zaretsky, 7/26, p. 18851.

Optimal vs. Other Levels of Deterrence



Dr. Zaretsky Misapplies The Theory of Deterrence

- Dr. Zaretsky's formula, "f > g / p", is not the fine specified by the theory of deterrence.
- None of the articles Dr. Zaretsky cites support this calculation of penalties.
  - Bentham and Hylton argue for the imposition of gain-based fines only when gains are less than harm.
  - Polinsky & Shavell and Dau-Schmidt argue for the imposition of gain-based fines only when gains arise out of "socially illicit" or criminal activity.

Criminal Benefits/Socially Illicit Gains

- Dr. Zaretsky admits purported gains at issue don't constitute criminal benefits.[1]

- Do they constitute "socially illicit" gains? No.

  – Socially illicit gains are defined as: "when the injurer's utility derives from causing harm itself, as when a person punches another out of spite or defames another to see him suffer. The injurer benefits because the victim suffers harm."[2]

  – Does not apply to corporations.[3]

Notes:
1. Testimony of Dr. Zaretsky, 7/27, p. 19049.
2. A. Mitchell Polinsky and Stven Shavell, Punitive Damages: An Economic Analysis, Harvard Law Review (1998), p. 909.
3. Polinsky and Shavell, p. 914.

Dr. Zaretsky's Probability of Detection and Enforcement

- Dr. Zaretsky's definition of "enforcement" is too narrow and inconsistent with the theory of deterrence.[1]

- His calculation of probability of detection and enforcement applies no discernable methodology.

$$P = D \times E$$

$$0.1 \neq 0.5^{2} \times (\text{range of } 0.5 - 0.9)^{3}$$

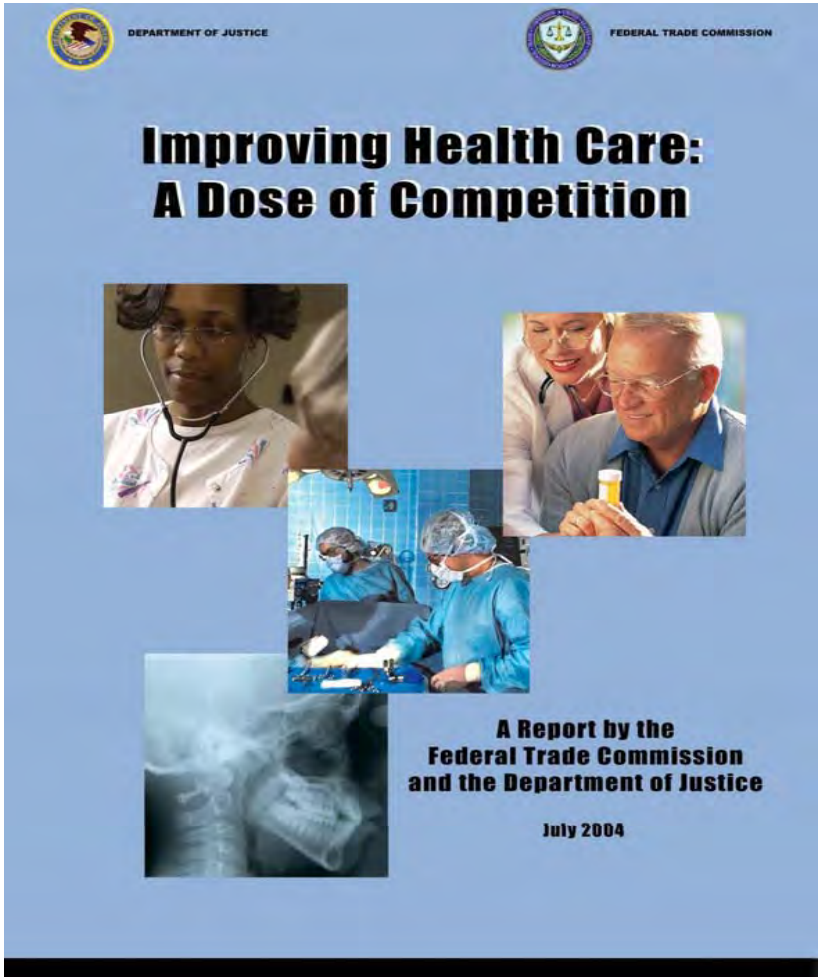
- His analysis fails to recognize that CDI has historically recovered costs of enforcement from insurers.

Notes:
1. Testimony of Dr. Zaretsky, 7/27, p. 19035.
2. 7/26, p. 18912
3. 7/27, p. 18935.

Optimal Deterrence By CDI

- Statutory framework for Unfair Practices Act emphasizes notice as requirement to assess penalties.[1]
- Regulations governing application of Ins. Code § 790.035 specifically seek "to promote the good faith, prompt, efficient and equitable settlement of claims *on a cost-effective basis.*"[2] [italics added]
- Specific regulation identifying factors in assessment of penalties:
  - Focus on harm, not gain.[3]
  - Require notice of noncompliant behavior.[4]
- Undertakings/NAIC Guidelines.

Notes:
1. Ins. Code § 790.035, 790.03, 790.06.
2. 10 CCR § 2695.1(a)(2).
3. 10 CCR § 2695.12 (a)(7), (8), (10), (12).
4. 10 CCR §§ 2695.12(a)(9), (13).



11th Observation:

Remedies must resolve the anticompetitive harm, restore competition, and prevent future anticompetitive conduct.

Remedies are a critical issue in implementing an effective competition policy. Optimal enforcement must steer between over-deterrence and under-deterrence. Over-deterrence may occur if conduct that is not, in fact, anticompetitive is challenged, or if excessive sanctions are imposed on anticompetitive conduct. Under-deterrence may occur if anticompetitive conduct is not identified and addressed, or if inadequate remedies are imposed in response to such conduct. The Agencies must avoid both of these extremes to effect optimal deterrence, while recognizing that bringing cases helps create a "compliance norm."

Summary of Opinions

I. According to economic principles, no penalty is appropriate in this case.

II. If the decision-maker determines that some penalty is appropriate, based on historical penalties, it should be between $0 and $655,289.

III. CDI's dealings with providers are relevant because they show that CDI became captive to their interests. Thus, the traditional deference to regulators should not be accorded here.

Harm In This Case Was Minimal

#	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

PacifiCare remediated all harm.

No Harm From Alleged EOP Omission

Number of Justified Complaints By Providers *Fell* After Revised EOP Form Language Was Included

Complaint Date	Before or After Revised EOP Form Language Included?	Number of Justified Complaints	Number of Justified Complaints per Thousand Members	Is Difference Statistically Significant?
12/16/06 - 6/15/07	Before	14	0.070	NO
6/16/07 - 12/15/07	After	11	0.077	

No Harm From Alleged EOB Omission

Number of IMRs *Fell* 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

Probability of Detection Near 100%

- Subject of an ongoing market conduct exam at the time that the alleged violations occurred.
- Under *additional* scrutiny by CDI as a result of PacifiCare's merger with United.
- CDI required PacifiCare to provide CDI with quarterly reports about its claims handling performance.
- *According to CDI*, PacifiCare took affirmative steps to disclose its conduct to CDI before PacifiCare had notice of the examination underlying the current enforcement action.[1]
- Significant provider engagement.

Notes: 1. Testimony of Nicoleta Smith, 12/8/09, p. 160; notice of examination was 5/7/07.

Lack of Notice

- No notice of "requirements" for acknowledgement letters.
  - Statute does not reference written acknowledgement letters and specifically contemplates acknowledgement by phone or website.
  - History of contrary interpretation.[1]
  - Admission by CDI that it did not communicate its new interpretation to health plans.[2]
- Conflicting notice of "late pays": Undertaking No. 19 and NAIC manual provide tolerance thresholds not followed by CDI here.
- No notice that alleged violations constituted § 790.03 violations.

Note: 1. DMHC interpretation, Ex. 5263. Legislative history of 10133.66(c) states that purpose of statute is to extend to CDI-regulated insurers the rules already applicable to entities regulated by DMHC.
2. Testimony of Craig Dixon, 3/8/10, p. 5320-1; testimony of Towanda David, 9/16/10, p. 11636.

Conflicting Assertions of § 790.03 Violations

- Language of § 790.03 itself doesn't tie to alleged violations.
- CDI admitted vast majority of allegations did not constitute a violation of § 790.03.
  - 2007 MCE Report cited only 90 alleged violations of § 790.03.
  - All of the six main categories of alleged violations classified as violations of other than § 790.03.

PacifiCare Market Conduct Exam -- Public Report

TABLE OF TOTAL CITATIONS

Citation	Description	# CITATIONS
CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies.	16
CCR §2695.3(a)	The Company's claim file failed to contain all documents, notes and work papers that pertain to the claim.	15
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.	15
CCR §2695.3(b)(3)	The Company failed to maintain hard copy claim files or maintain claim files that are accessible, legible and capable of duplication to hard copy for five years.	14
CCR §2695.5(b)	The Company failed to respond to communications within 15 calendar days or with a complete response based on the facts as then known by the licensee.	11
CCR §2695.11(b)	The Company failed to provide an explanation of benefits or a clear explanation of benefits.	8
CCR §2695.3(b)(2)	The Company failed to record in the file the date the Company received, date the Company processed and date the Company transmitted or mailed every relevant document in the file.	4
CCR §2695.5(a)	The Company failed to respond to a Department of Insurance inquiry within 21 calendar days.	3
CCR §2695.7(g)	The Company attempted to settle a claim by making a settlement offer that was unreasonably low.	2
CIC §790.03(h)(1)	The Company failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue.	2
Total Citations		**90**

PUBLIC REPORT
(PURSUANT TO INSURANCE CODE SECTION 12938)

OF THE MARKET CONDUCT EXAMINATION

OF THE CLAIMS PRACTICES OF THE

PACIFICARE LIFE AND HEALTH INSURANCE COMPANY
NAIC # 70785 CDI # 3086-6

"This report contains alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al."

SUMMARY OF EXAMINATION RESULTS

Money recovered within the scope of this report was $667.66

90

PacifiCare Market Conduct Exam -- Confidential Report

"This report contains alleged violations of laws **other than Section 790.03** and Title 10, California Code of Regulations 2695 et al."

	ACCIDENT AND DISABILITY 2006 Written Premium: $843,721,575	NUMBER OF CITATIONS		
	AMOUNT OF RECOVERIES **$155,787.40**	Electronic Paid Claims Review	Sample File Review	Total
"Late Paid" claims & No EOP review notice →	CIC §10123.13(a)	42,137	139	42,276
	CIC §734	0	45	45
	CIC §790.02	0	47	47
EOB - No IMR Notice →	CIC §10169(i)	0	27	27
No Interest on "Late Pays" →	CIC §10123.13(b)	5432	17	5449
	CIC §10123.137(c)	0	14	14
	CIC §10123.147(a)	0	5	5
No acknowledgment letter →	CIC §10133.66(c)	81,280	6	81,286
	CIC §10123.13(c)	0	2	2
	CIC §10198.7(a)	0	2	2
	SUBTOTAL	**128,849**	**304**	**129,153**

Summary of Opinions

I. According to economic principles, no penalty is appropriate in this case.

II. If the decision-maker determines that some penalty is appropriate, based on historical penalties, it should be between $0 and $655,289.

III. CDI's dealings with providers are relevant because they show that CDI became captive to their interests. Thus, the traditional deference to regulators should not be accorded here.

Why Historical Penalties Are Important

- Historical penalties constitute a form of notice.
- Penalty, if any, must be consistent with historical penalties.
  - CDI acknowledges consistency as one of its key goals.[1] Deputy Commissioner Laucher agrees.[2]
  - Consistency is also important under principles of economic theory.

Notes: 1. California Department of Insurance, Field Claims Bureau Procedures Manual, Ex. 5411.
2. Laucher, 11/3/10 p. 13186.

California Department of Insurance

Values

- *Honest, open and fair;*
- *Knowledgeable, accurate, and consistent;*
- *Accessible, responsive, and accountable;*
- *Efficient, effective, and to provide innovative leadership.*

Vision

- *To be the best insurance department in the nation!*

Mission

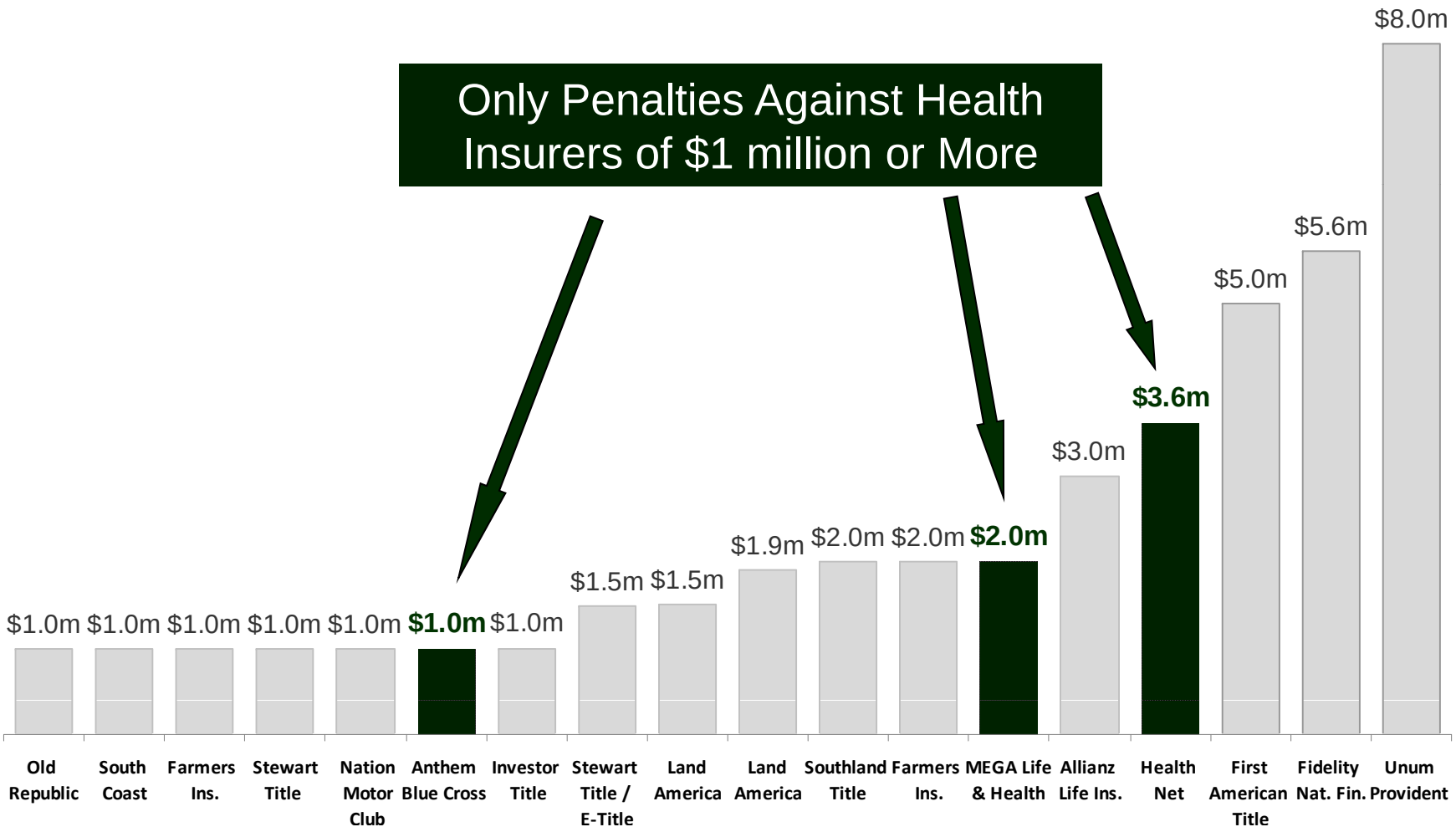
- *Protect consumers;*
- *Foster a vibrant, stable marketplace;*
- *Maintain an open, equitable regulatory process; and*
- *Fairly and impartially enforce the law.*

Dr. Zaretsky's Proposed Penalties Are Not Consistent with CDI Historical Penalties

Total Penalties for 2002-2009

Year	Penalties Resulting from Market Conduct Division Legal Actions (Per CDI Annual Report)	Number of Actions Finalized by Legal Branch Due to Market Conduct Division Exam Findings	Number of Exams Adopted by Commissioner
2002	$ 776,500	4	324
2003	$ 1,264,157	11	360
2004	$ 1,750,000	9	290
2005	$ 14,683,000	17	289
2006	$ 1,227,000	10	271
2007	$ 10,545,500	10	174
2008	$ 4,700,000	7	176
2009	$ 2,465,000	6	207
TOTAL	**$ 37,411,157**		

CDI Penalties Against Insurers of $1 million or More (2000-2009)



Source: CDI press releases.

Scaling Past Penalties to the Current Case

- Reference to specific number of violations cited is misleading.
  - It doesn’t reflect severity of harm.
  - All enforcement actions other than PacifiCare are based on a sample.
- Accordingly, past penalties need to be normalized to compare to violations alleged here.

Scaling Past Penalties Based on Harm

$$\text{Penalty in this case} = \frac{\text{Penalty in past case}}{\text{Harm in past case}} \times \text{Harm in current case}$$

- If this case involved twice as much harm → penalty in this case twice as large.
- If this case involved half as much harm → penalty in this case half as much.
- Information available: membership information, amounts paid in MCEs, and total recoveries as proxies for relative harm.

Three Measures of Harm

- *Number of member-years*: number of members affected times number of years covered by the MCE.
- *Amount recovered within MCE*: amounts recovered by CDI represent one assessment of the harm caused.
- *Total amounts paid*: amounts paid by insurers represent an alternative (broader) assessment of harm.

Harm Comparison: PacifiCare vs. Blue Shield, Anthem, and Health Net

Company	Number of Member-Years	Recoveries Within Scope of MCE	Additional Recoveries Reported by CDI	**Total Paid Amounts**
PacifiCare	166,317	$156,455	0	**$156,455**
Blue Shield of California	1,410,143	$1,036,114	Undisclosed	**$1,036,114 + Undisclosed**
Anthem Blue Cross	941,667	Undisclosed	$14,000,000	**$14,000,000 + Undisclosed**
Health Net	916,638	$1,224,500	$21,400,000	**$22,624,500**

Sources: CDI Market Conduct Exams; CDI press releases.

Adjusted Historical Penalties Between $0 and $650k

	Anthem Blue Cross	Blue Shield	Health Net	United Multistate	MEGA Multistate
Penalty	$1,000,000	$0	$3,600,000	$260,294	$2,016,735
Penalty Per Unit of Harm In Past Cases					
Penalty/member-year	$1.06	$0	$3.93	$1.10	$3.94
Penalty/$ MCE recovery	*	$0	$2.94	*	*
Penalty/$ total amounts paid	$0.07	*	$0.16	*	*
Implied Penalty In This Case					
Based on number of affected member-years of:					
166,317	**$176,296**	**$0**	**$653,626**	**$182,949**	**$655,289**
Based on amount recovered within MCE of:					
$156,455	*	**$0**	**$459,978**	*	*
Based on total amounts paid of:					
$156,455	**$10,952**	*	**$25,033**	*	*

Summary of Opinions

I. According to economic principles, no penalty is appropriate in this case.

II. If the decision-maker determines that some penalty is appropriate, based on historical penalties, it should be between $0 and $655,289.

III. CDI's dealings with providers are relevant because they show that CDI became captive to their interests. Thus, the traditional deference to regulators should not be accorded here.

The Problem of "Regulatory Capture"

- Regulatory capture is a well established economic theory that describes when a special interest group takes advantage of the regulatory process for its own benefit.

- Capture most likely to occur when:
  - Interest groups are small, homogeneous and well-organized;
  - Benefits of capture are concentrated and costs to consumers are diffuse; and
  - Issues are complex and hard for voters to understand.
  - Interaction between regulators and interest groups takes place in "informal and nontransparent ways that [r]aise concerns about inequalities of interest group access."[1]

- Recognized as an important problem across the political spectrum.

Notes: 1. Elena Kagan, Presidential Administration, Harvard Law Review (2001) Vol. 114, p. 2267.

Why Regulatory Capture Is Important Here

- There is substantial evidence that CDI became captive to the private financial interests of doctors and hospitals in this case.
- Influence of California Medical Association and the University of California hospital system are most notable.
- Missing CDI documents make it difficult to assess the degree to which capture extended beyond specific providers identified.[1]

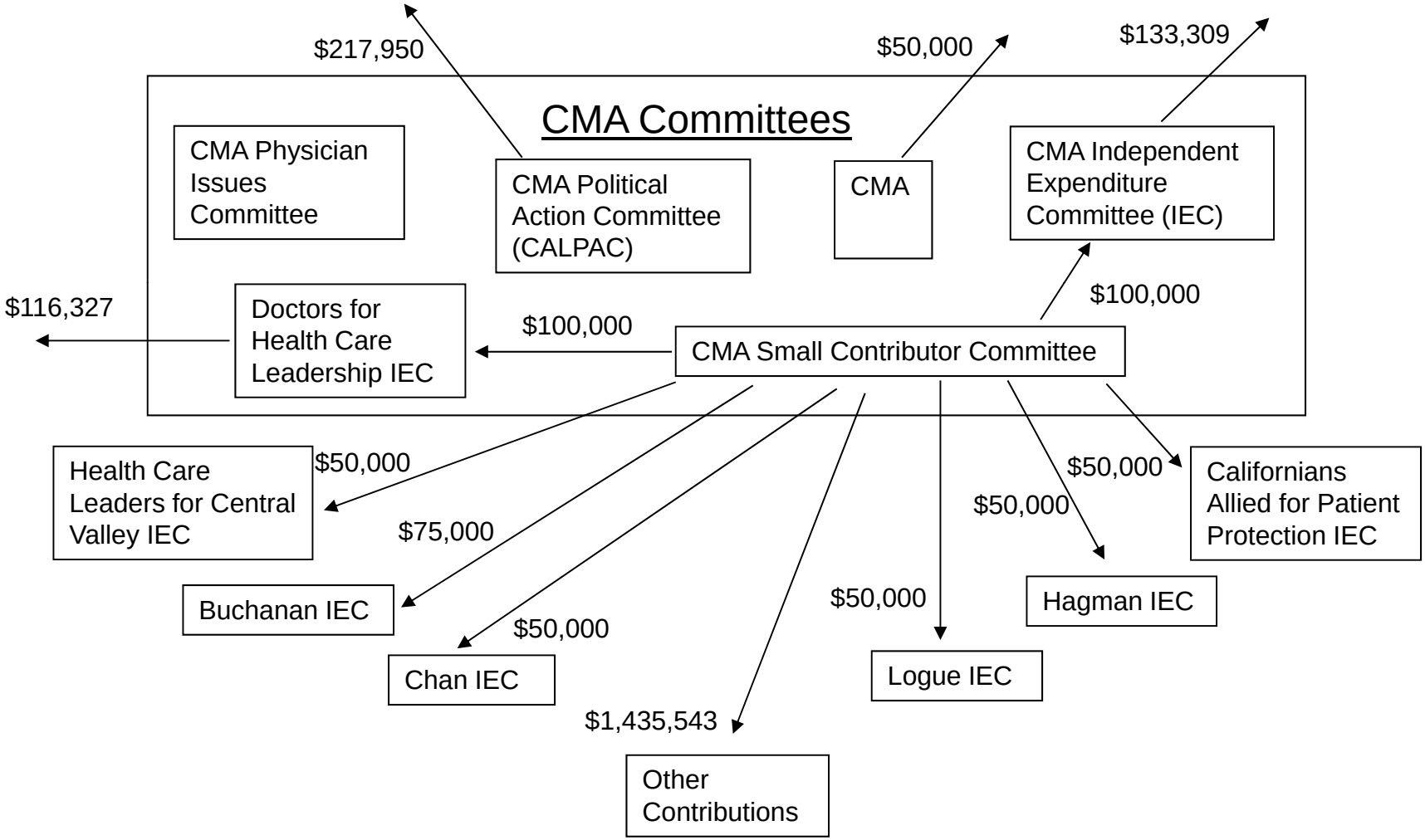
Notes: 1. Letter to Judge Astle from Bryce Gee, 11/8/10.

California Medical Association

- Professional medical association for doctors in California.
- Meets classic criteria:
  - Small and homogeneous membership.
  - Broad coverage of Congressional districts.
  - Influential within the state.[1]
  - Extensive lobbying activities.
  - Significant political contributor.
- Conflict between interests of consumers and providers not evident.

Notes: 1. CMA CEO Dustin Corcoran and CMA Vice President of Government Relations Jodi Hicks named to Capitol Weekly's "Top 100," a ranking of the most powerful players in California politics. Capitol Weekly, April 28, 2011.

Web of CMA Affiliates and Political Action Committees

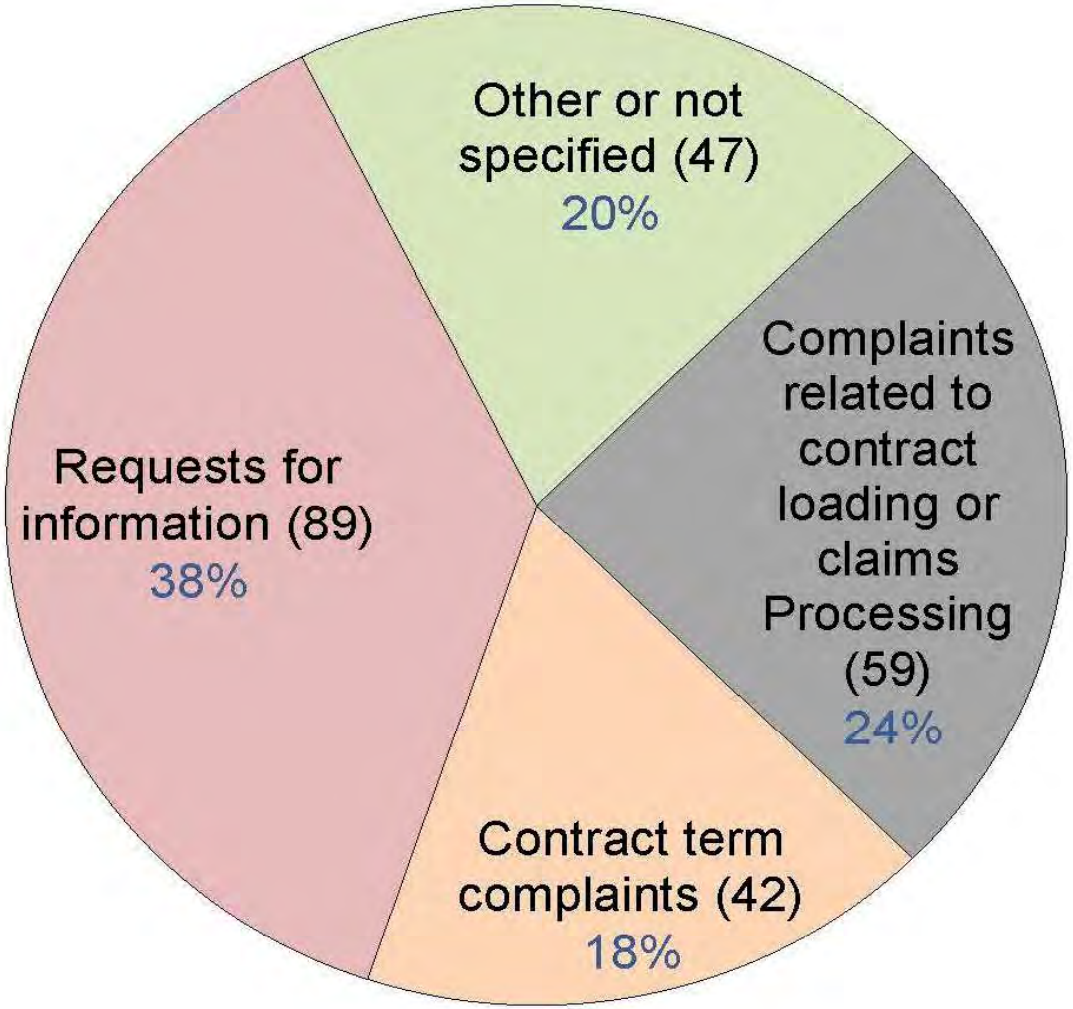


Source: http://cal-access.ss.ca.gov. Figure reports all contributions and expenditures by CMA Committees of $50,000 or more for the period 2007-08.

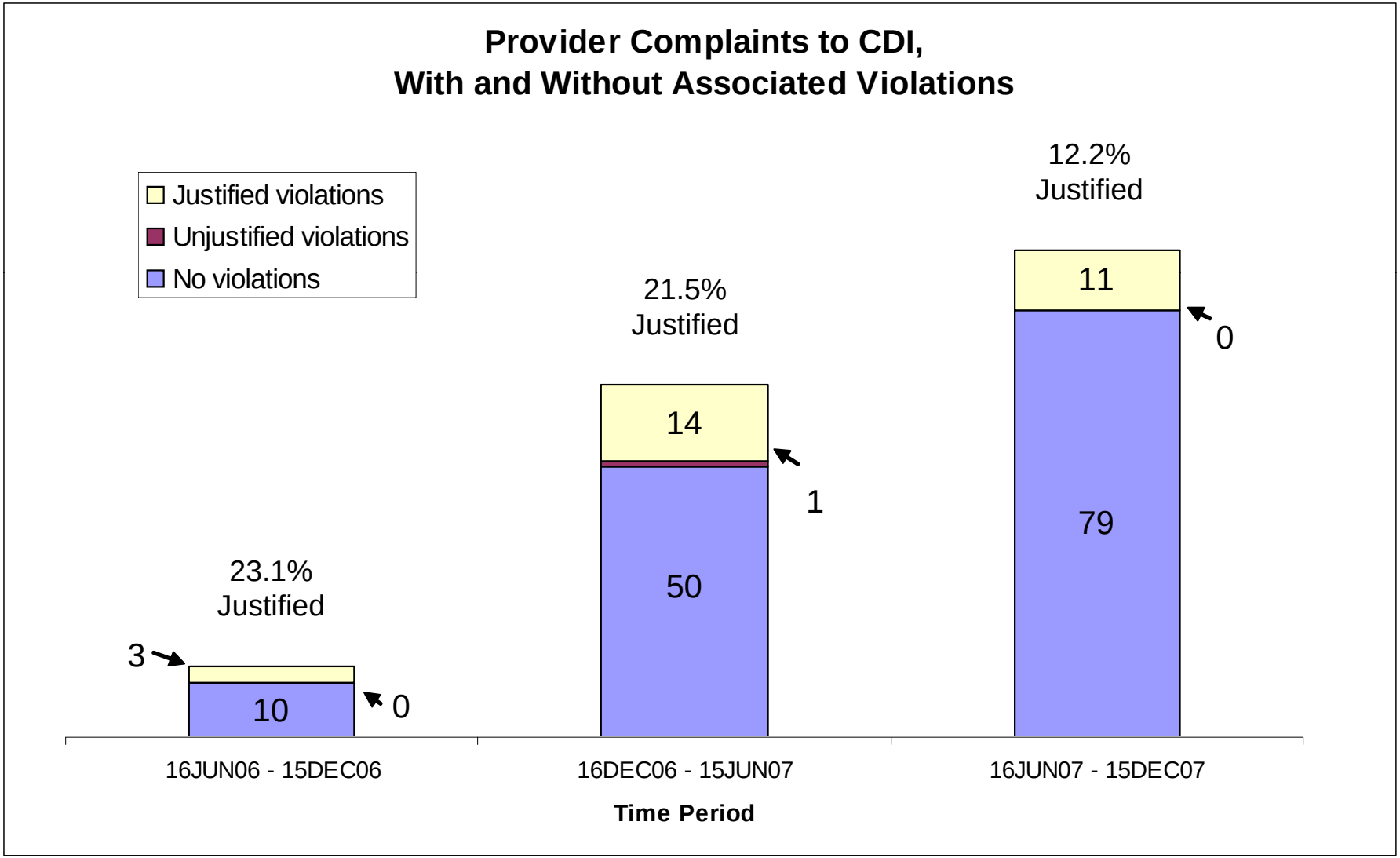
Extensive Evidence of Capture

- Accepted unsubstantiated reports of provider complaints from CMA.
- Discussed contract terms with providers despite having no jurisdiction.
- Identified “unfair contract terms” with providers as an issue to be resolved with PacifiCare.
- Created the conditions that would justify bringing an enforcement action.
  - “The more numbers racked up, the better”
  - Waived established limitations on filing complaints.
- Admitted that CMA’s “teaching and influence” expanded the scope of the investigation.
- Undertook enforcement activity disproportionate to harm.

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



Most Provider Complaints Unjustified



Recent Study Confirms Concerns About Capture and Provider Market Power in CA

According to a 2010 study published in the peer-reviewed health policy journal *Health Affairs*, provider market power and regulatory capture are key drivers of the high cost of health care in California:[1]

WEB FIRST

By Robert A. Berenson, Paul B. Ginsburg, and Nicole Kemper

Unchecked Provider Clout In California Foreshadows Challenges To Health Reform

DOI: 10.1377/hlthaff.2009.0775
HEALTH AFFAIRS 29,
NO. 4 (2010): 699–705
©2010 Project HOPE—
The People-to-People Health
Foundation, Inc.

ABSTRACT **Faced with declining payment rates, California providers have implemented various strategies that have strengthened their leverage in negotiating prices with private health plans. When negotiating together, hospitals and physicians enhance their already significant bargaining clout. California's experience is a cautionary tale for national health reform: It suggests that proposals to promote integrated care through models such as accountable care organizations (ACOs) could lead to higher rates for private payers. Because antitrust policy has proved ineffective in curbing most provider strategies that capitalize on providers' market power to win higher payments, policy makers need to consider approaches including price caps and all-payer rate setting.**

Robert A. Berenson (rberenson@urban.org) is a senior consulting researcher at the Center for Studying Health System Change and an Institute Fellow in the Health Policy Center at the Urban Institute, both in Washington, D.C.

Paul B. Ginsburg is president of the Center for Studying Health System Change.

Nicole Kemper is a former health research analyst at the Center for Studying Health System Change.

In current health reform discussions and proposed legislation, providers' growing market power to negotiate higher payment rates from private insurers is the "elephant in the room" that is rarely mentioned. Here, in our study of the current negotiating environment in California, we explain that growing market power for providers caused a shift that gave providers a stronger bargaining position over health plans, leading in turn to higher insurance premiums.

Further, we explore why some of the proposed payment reforms and organizational delivery models—including so-called accountable care organizations (ACOs)—that have been championed at the national level have the potential not only to produce higher quality at lower cost but also to exacerbate the trend toward greater provider market power. Such provider dominance could offset some or all of the potential of reforms to lower premiums through increased efficiency in delivery.

The trends in California suggest an urgent need for policy makers to address the issue of growing provider market strength. In our judgment, more active antitrust enforcement will not do the job. Rather, more direct regulatory approaches, including all-payer rate setting, need to be actively considered.

On average nationally, commercial insurers' hospital and physician payment rates are nearly 30 percent and 20 percent higher, respectively, than Medicare rates.[1,2] Evidence from two decades of hospital mergers and acquisitions nationally demonstrates that consolidating hospital markets drives up prices, with disagreement only over the magnitude of the increases.[3] Some researchers have concluded that formation of hospital systems has primarily served to increase market power—not improve quality or efficiency of patient care—at least in the short run.[4]

A recent study has shown that in California, after a downward trend in hospital prices for private-pay patients in the 1990s, a rapid upward trend began about 1999 that produced average annual increases of 10.6 percent over the period 1999–2005. The study's authors concluded that the source of the near-doubling of California hospital prices remains "something of a mystery."[5]

Analysis of Medicare Cost Report data by the Medicare Payment Advisory Commission (MedPAC), although national, shows that inpatient costs per admission increased only 5.5 percent

Downloaded from content.healthaffairs.org by Health Affairs on May 24, 2011
at STANFORD UNIV MED CTR

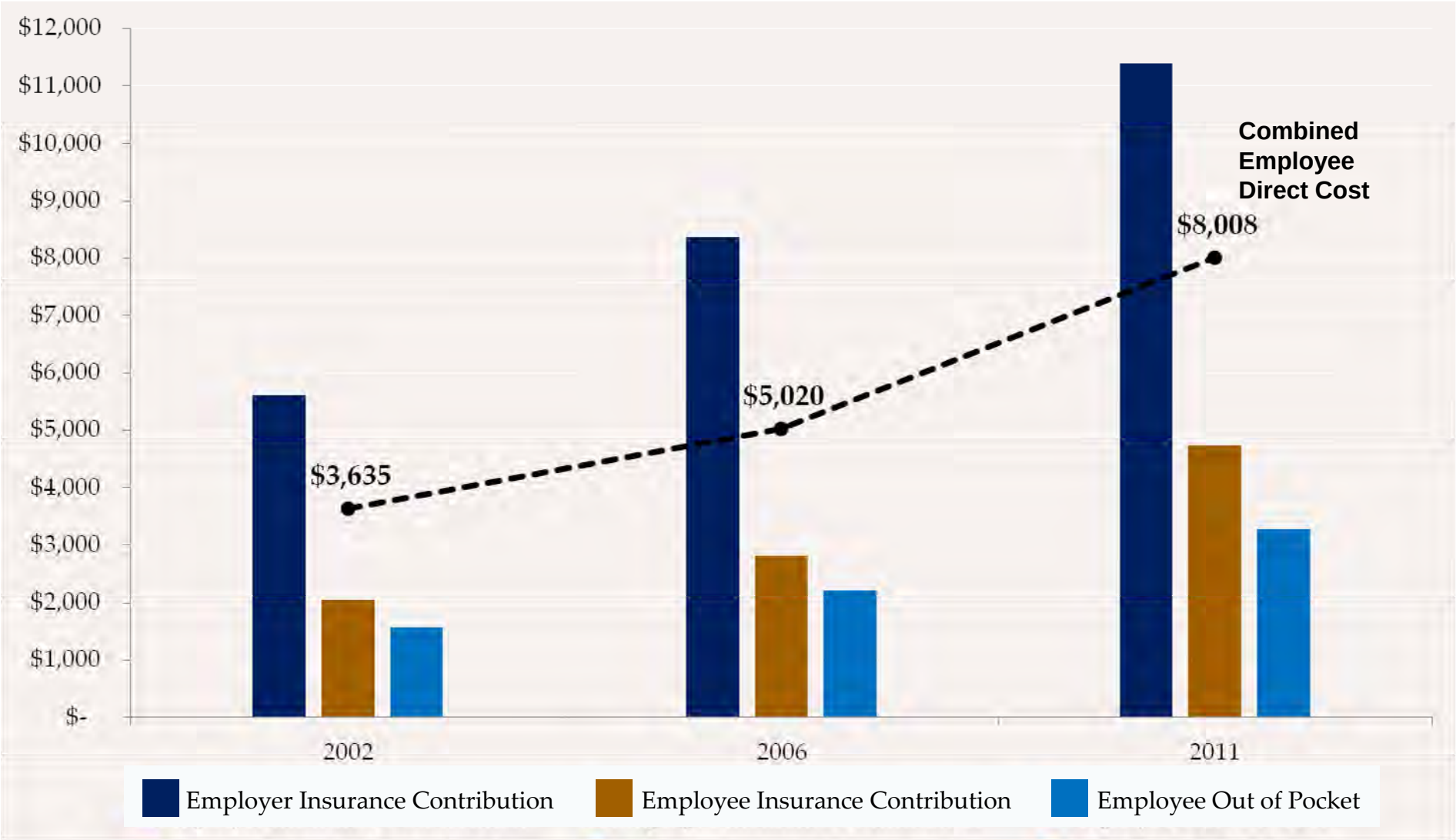
REGULATORY ENVIRONMENT Health plan and provider representatives also point to a regulatory environment in the aftermath of the managed care backlash that appears to favor providers in negotiations.

Discussion

The shift in who holds the upper hand in negotiating payments—once held by health insurance plans but now resting with health care providers—has had a major impact on California premium trends. According to some survey respondents, the dynamic needs urgent policy attention.

Notes: 1. Robert Berenson, Paul Ginsburg, and Nicole Kemper, Unchecked Provider Clout in California Foreshadows Challenges to Health Reform, Health Affairs 29 (2010): 1-7.

Rising Costs Affect Both Consumers and Employers



Source: Milliman Medical Index, 2006 and 2011 reports.

Impact of Regulatory Capture In This Case

- Case does not serve consumers' interests.
- Deference generally accorded to the regulator should not be accorded here.
- Liability and penalties premised on exercise of judgment by CDI which may have been affected by capture:
  - Novel interpretation of acknowledgement statute.
  - Disregard of tolerance thresholds in Undertakings and NAIC Guidelines.
  - Application of § 790.03 to categories of violations not treated as such in the original MCE.
  - Contentions of the magnitude of harm and gain.
  - Seeking an unprecedented fine.