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BEFORE THE INSURANCE COMMISSIONER

OF THE STATE OF CALIFORNIA

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

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I. SUMMARY

In offering its recommended penalty in this case, the California Department of Insurance ("CDI") breaks with its own precedent and that of regulators outside the state. Its positions, as reflected in the testimony of Deputy Commissioner Tony Cignarale, indicate a troubling level of arbitrariness and subjectivity that appears driven at least in part by CDI's strategic approach to this litigation. The penalty provisions of Section 790.035 should not apply to the conduct at issue, and, even if they did, the penalty, if any, should be consistent with penalties historically assessed by CDI. The challenged conduct here involves routine market conduct exam issues, a point that is obscured by CDI's repeated and misleading insistence on looking at the raw number of alleged violations. The company remediated the issues, and the harm in this case pales in comparison to the cases where CDI has imposed significant penalties. In my opinion, CDI's approach here is not consistent with the law and will adversely affect consumers and the insurance markets in California more generally.

II. QUALIFICATIONS

I have significant experience in insurance regulation and, in particular, market conduct investigations, examinations and enforcement proceedings. For nearly 15 years, I served as an insurance regulator with the Ohio Department of Insurance, as both a staff attorney and in a senior management position with policymaking responsibilities. I served as the Assistant Director for the Office of Investigations and Licensing, responsible for three divisions - Market Conduct, Fraud & Enforcement and Agent Licensing. In the course of my tenure as a regulator, I was active in many committees of the National Association of Insurance Commissioners ("NAIC"). I chaired the committee that developed the Market Conduct Annual Statement, a project which is now a permanent market analysis tool used by over 40 states. I also chaired the Producer Licensing Uniformity Working Group, Limited Lines subgroup and a subgroup that amended the Third-Party Administrators Licensing Model Act.

I am Vice-Chair and Agenda Chair for the Insurance Regulatory Examiners Society ("IRES") Foundation, a not-for-profit organization that provides financial support for educational initiatives for insurance regulators. I recently served as the Chair of the Insurance Regulation Committee of the American Bar Association and a member of Association of Insurance Compliance Professionals. I earned the Chartered Property & Casualty Underwriter designation and the Market Conduct Manager designation. I regularly attend NAIC meetings and other industry events.

My full curriculum vitae is attached as Appendix A.

III. FUNDAMENTAL PRECEPTS RELATING TO INSURANCE REGULATION.

CDI's website provides a concise description of the goals of insurance regulation:

> CDI ensures that consumers are protected; that the insurance marketplace is fostered to be vibrant and stable; that the regulatory

process is maintained as open and equitable; and that the law is enforced fairly and impartially.

http://www.insurance.ca.gov/0500-about-us/0100-cdi-introduction/

The objective to protect consumers guides the activities of insurance regulators to monitor and control the conduct of licensed insurance entities in their respective jurisdictions. Early regulatory attention was concentrated on the financial solvency of insurance companies. After all, if an insurer is not solvent, it will not be around to honor the promises intended to protect consumers from the risk of loss. Over time, the scope of regulatory focus broadened to encompass standards for the conduct of insurers and agents and brokers in the marketplace, including the handling of insurance claims. In recent years, many states enacted laws governing the prompt payment of healthcare claims and laws that protect the interests of medical providers. The California Provider Bill of Rights is an example of such a law. The benefits to providers are obvious – interest requirements that incentivize claims payment timeliness and other provisions ensuring providers have certain contract, appeal and dispute resolution rights. The underlying rationale of those laws, however, remains consumer protection.

In looking at practices and approaches to regulation, the NAIC is a critical resource for regulators. The membership of the NAIC is limited to insurance regulators; there are no industry members although the industry actively participates in NAIC initiatives and meetings. California has been and continues to be active at a national level on many issues at the NAIC and other insurance industry forums. The California examination statute, Section 733, requires the observance of the guidelines and procedures of the NAIC Examiner's Handbook, the predecessor to today's Market Regulation Handbook. The NAIC has developed this handbook (as well as a handbook relating to financial examinations) to provide guidelines for states to use in coordinating regulatory monitoring and enforcement activities. These handbooks contain "best practices" that are developed and culled from regulators around the country after a great deal of discussion and analysis. In addition, California has enacted legislation incorporating provisions of NAIC model acts, including those governing unfair trade practices and claims settlement practices.

As CDI notes on its website, one of its purposes is to ensure "that the insurance marketplace is fostered to be vibrant and stable." Regulators strive to keep the industry aware of regulatory developments, including the regulator's interpretation of statutory requirements and the regulator's expectations of the industry. By doing so, regulators create a consistent and predictable regulatory environment and robust insurance market in which all insurers understand and are governed by the same rules. CDI Deputy Commissioner Joel Laucher testified that it is important for the regulatory process to be fair to insurers and as transparent as possible.

IV. CDI'S ARBITRARY AND SUBJECTIVE APPROACH.

As stated above, CDI's mission statement identifies these laudable, typical goals: to protect consumers, foster a vibrant and stable marketplace, maintain an open and equitable regulatory process, and enforce the law fairly and impartially.

It appears to me that CDI has advocated positions *in this proceeding* that undermine these objectives. CDI has emphasized monetary penalties from the outset and has shown substantially less interest in corrective actions, claims remediation or compliance. It has applied a "zero

tolerance" standard for late claims payment -- even in the face of a company's claims-paying performance that meets a standard previously accepted by the regulator. It has disregarded its own policies, procedures and precedents in the course of its examination and subsequent enforcement action, which is contrary to an open and equitable regulatory process. It has applied novel and previously unexpressed interpretations of law to a single insurer to support a request for a monetary penalty, which likewise does not appear to be fair and impartial enforcement of the law. It created a new methodology for determining the amount of penalties for this particular insurer. These are just several of the many examples of conduct that, in my opinion, reflect a failure to apply objective standards, resulting in greater likelihood of subjective and disparate treatment.

A. Penalty Methodology Not Based On Law Or Precedent.

Mr. Cignarale's process for calculating a penalty is new, untested and not based on the applicable statute and regulation (Ins. Code § 790.035 and 10 CCR § 2695.12). Significantly, his methodology was developed specifically for this case and has never been applied by CDI nor by any other regulator of which I am aware. Mr. Cignarale does not explain the need for developing a new methodology for this case. The penalties authorized by Section 790.035 do not change regardless of whether a matter goes to hearing or is settled before hearing. The requirement to apply specific factors to determine the amount of a penalty is the process described in Section 2695.12.

Nevertheless, Mr. Cignarale created the concept of a "generic" penalty which forms the "starting point" for his analysis. Nothing in Section 790.035 or Section 2695.12, however, permits CDI to start its analysis with an abstract, "generic" penalty exists or is supposed to be created for the violation of any particular law. In fact, the factors in Section 2695.12 are specific to the particular conduct and regulated entity at issue. Significantly, Mr. Cignarale's starting point is a number in excess of $1 billion for a hypothetical insurer based upon his view of "generic" violations before he even considers the factors enumerated in Section 2695.12. That starting point assures that the penalty ultimately assessed from this methodology will be significantly higher than any penalty ever previously assessed in California.

In addition to lacking any legal basis, Mr. Cignarale's approach is subjective and internally inconsistent. First, he derived a "generic" starting point based on his "experience" without using any quantitative measures. Remarkably, that figure barely changes even after he said he applied the factors in Section 2695.12 to the evidence in this case. He then essentially puts that calculation aside and reduces the amount because the astronomically high penalty would put PacifiCare in a hazardous financial condition. Then, without applying any formula, standards or objective considerations, he comes up with a wholly different figure that essentially "feels right." It is not subject to verification, cannot be independently derived and has no evident relationship to the number of violations. Indeed, Mr. Cignarale testified that his total recommended penalty would not be adjusted downward even if up to 700,000 alleged violations were dismissed. That is inconsistent with the applicable regulations and anything I have ever seen before as a regulator. In addition, at no point during the process does Mr. Cignarale take into account recent penalties imposed on other insurers.

B. Unwillingness To Adhere To Own Published Rules.

A serious cause for concern is CDI's disregard for following its own procedures in this case. For example, CDI's manuals emphasize that compliance officers, as a threshold matter are required to determine if a complaint comes within CDI's jurisdiction. This preliminary step was disregarded for certain special complainants. CDI compliance officers further deviated from standard procedures by not requiring providers to exhaust PacifiCare's internal company appeals process before processing complaints. Compliance officers also failed to adequately maintain documents pertaining to this matter. In the course of the examination of PacifiCare, CDI also deviated from its standard protocol and did not provide PacifiCare with statutory citations in referrals or, significantly, with an opportunity to review and comment informally upon an initial draft of CDI's report. These and other deviations from CDI's own procedures and guidelines invite arbitrariness and subjectivity into the regulatory process and raise questions about the motive for such deviations. Similarly, CDI disavowed the relevance of the guidelines set forth in the NAIC Market Regulation Handbook, even though Section 733, relied upon by CDI in calling the examination in this case, requires CDI to observe those guidelines.

C. Positions Inconsistent With Previous Actions.

CDI has taken positions in this litigation that contradict its prior positions without any discernible or credible explanation other than those new positions advance CDI's litigation strategy. This conduct demonstrates a level of arbitrariness and subjectivity that is unacceptable for a regulator and can create uncertainty for the regulated entity and for the industry more generally, which can adversely affect consumers.

Some examples deserve specific attention. CDI accepted and adopted the Undertakings standards. Mr. Cignarale nevertheless contends that the Undertakings have no relevance in this matter and attributes no significance to the fact that PacifiCare met these claims-handling standards accepted by the Commissioner. It makes no sense to me that a regulatory body could establish acceptable performance standards for a specific regulated activity and later ignore those standards and assert that conduct that satisfies those standards is an unfair trade practice. In my experience, this type of inexplicable change in standards and expectations by a state agency is an indication that the regulator is acting in an arbitrary manner which is likely to result in subjective and disparate treatment.

CDI also significantly changed its position as to what constitutes an unfair trade practice after the examination report was finalized and even after the Order To Show Cause was filed. CDI issued official, public statements of its position (examination reports, Order to Show Cause) that informed the public about the Section 790.03 violations PacifiCare had allegedly committed. By law, CDI is charged with issuing a public report of all examinations of conduct violating Section 790.03. The vast majority of the conduct which CDI now alleges to be Section 790.03 violations, however, were not included in CDI's public report but instead were included in the non-public report that covers conduct that does not violate Section 790.03. Insurers should be able to rely upon those important assessments when made by a regulator. To suggest that the field examiners were not capable of determining what constitutes an unfair business practice does not make sense because these are precisely the people charged with detecting such violations. I understand from testimony in the case that both the exam reports and the Order to Show Cause were specifically reviewed by senior management and counsel. If in fact they

believed that the charges were violations of Section 790.03, the reports and Order to Show Cause should have reflected that position.[1]

CDI has also changed its position regarding the regulator's role in the day-to-day business operations of insurers it regulates. Until this hearing, CDI took the position that it should not get involved in operational details. However, throughout this hearing, CDI has criticized legitimate business decisions regarding systems, procedures, staffing and other business issues. In fact, the suggestion throughout this hearing has been that those decisions were in some way improper or even illegal. That is simply not behavior that one typically sees by regulators.

D. CDI's Interpretation and Enforcement of Particular Statutes.

CDI has proffered interpretations of various Insurance Code provisions in this proceeding that do not appear to be based on any internal or published CDI guidance, and that have not been enforced against other insurers as far as I can tell. Based on the evidence and authorities I have reviewed, CDI's interpretations appear to have been created for the purposes of affecting the outcome of this proceeding, without regard to the consequences such positions may create for the insurance industry and consumers. At a minimum, some of these interpretations will likely result in unreasonable and impractical regulation of insurance companies in this state.

In the most tangible example of this behavior, CDI asserts that every explanation of payment form ("EOP") and explanation of benefits form ("EOB") issued by PacifiCare during the period in question was non-compliant. CDI reaches that conclusion, however, only by taking a strained and overly expansive view of what is a denied or contested claim. Section 10123.13(a) requires notice with respect to "denied or contested" claims. The right to an Independent Medical Review ("IMR") under Section 10169(i) is triggered in very rare instances when medical services are denied on the grounds of medical necessity-- a point CDI does not itself dispute. However, CDI asserts that all the claims at issue, even those that were paid, are in fact denied or contested claims on the theory that any claim paid at less than billed charges is "denied" or "contested" -- even though the provider may have contractually agreed to the reduction from billed charge. In my years of experience in the industry, I have never heard anyone, let alone a regulator, take such a position regarding what constitutes a denied or contested claim. Indeed, market conduct exams (including the exam at issue in this case), compliance audits and complaint handling mechanisms employed by CDI and other regulators rely on terms such as "denied claims" or "paid claims" within their ordinary meaning to determine categories of claims data.

CDI's own conduct does not support its stated view that the IMR statute requires including the form language on the EOB. Section 10169(i) became effective in 2001. Presumably, CDI's Consumer Services Bureau has received and reviewed, since 2001, thousands of EOBs issued by a host of health insurers. And yet CDI has never taken the position, prior to this proceeding, that EOBs required notice of IMR rights. Indeed, a number of large PPO

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[1] Indeed, Mr. Cignarale admits that there was nothing in the draft market conduct examination reports that would have put the company on notice of its more recent contention that all of the charged conduct constituted violations of Section 790.03.

insurers in California do not include such language on their EOB forms and yet I have seen no evidence that any action was ever taken against those insurers by CDI. The fact that CDI has not taken any action leads me to conclude that its current interpretation was developed for purposes of this case.

I have similar concerns with regard to CDI's interpretation of Section 10133.66(c) to require the issuance of a written acknowledgement letter for any paper claim not paid within 15 days. This interpretation seems to me to be unsupported by the plain language of the statute, the legislative history of the enacting bill (SB 634), the language of 28 CCR Section 1300.71, which is specifically attached to the legislative history, and the testimony of CDI and PacifiCare witnesses and related exhibits. Rather than recognizing that the statute at issue is at least reasonably susceptible to the interpretation offered by PacifiCare, and as adopted by the Department of Managed Health Care ("DMHC"), Mr. Cignarale simply asserts that the statute is unambiguous in its requirement that a letter be sent and simply disclaims the import of the legislative history and DMHC's interpretation of the substantially identical language of Section 1300.71(c). While a regulator has some discretion to interpret the applicable laws, it cannot do so without regard to the actual language of the statute and to the precedent that precedes its implementation. At minimum, once CDI decided to interpret this statute differently than its sister agency, it should have provided notice of its interpretation to the industry, which it concedes it did not.

As with its definition of a denied claim (as applied to EOBs and EOPs) and the requirement to place notice of IMR rights on all EOBs, I am struck by the fact that CDI has not been able to provide any evidence that it has consistently applied these new interpretations of law at any time prior to this proceeding.

E. Departure From Historical Precedent.

CDI's conduct toward PacifiCare represents a significant departure from its historical practices and how it has treated other insurers. In my view, the manner in which CDI has dealt with PacifiCare is unprecedented – both from the standpoint of CDI's own history, and my experience as a former regulator, a participant in the NAIC, and regulatory lawyer. This departure from historical practices has resulted in CDI attempting to impose on PacifiCare a shockingly large penalty that bears no reasonable relationship to any prior penalties levied by CDI. That is not consistent with anything I have seen in my extensive regulatory experience.

V. REGULATORS SHOULD BE FAIR AND IMPARTIAL.

Because regulators exercise discretion and power, they must act objectively and fairly, avoiding any indication of bias. As CDI staff testified, regulators should be impartial. However, the record reflects that CDI has not acted as a neutral, objective regulator. The events leading up to the examination of PacifiCare, the examination itself and the course of this enforcement action are marked by a series of aberrations, not the least of which is CDI's focus on increasing the number of violations charged against PacifiCare. In particular, it seems reasonably clear that CDI was subjected to considerable pressure from influential providers and the California Medical Association ("CMA") in the months leading up to the examination. CDI did not, however, appear to demonstrate the requisite level of impartiality consistent with what one would typically see when a regulator is pressured by outside entities. Instead, CDI went beyond being sympathetic to CMA's concerns and appeared to coordinate the investigation and

enforcement action with CMA. In addition, there are indications that the Commissioner and his senior management became predisposed against the company even during the investigation such that the question became not whether the company should be punished, but how best to accomplish it. CDI then took a number of steps that were out of the ordinary and not consistent with what a regulator would typically do. It is not credible to think that the Commissioner's staff would act inconsistently with the Commissioner's very public views.

VI. ANALYZING INSURER CONDUCT UNDER SECTION 790.03(h) AND SECTION 2695.12.

Based on the governing statutes and regulations, and my experience in the industry, the correct approach to analyzing insurer conduct for the purpose of assessing penalties is threefold.

- First, is the conduct at issue one of the enumerated activities specified in subsection 790.03(h) as an unfair trade practice?

- Second, if the conduct at issue is one of the enumerated activities specified in subsection 790.03(h), does the challenged conduct implicate a general business practice?

- Third, if the answer to those questions is yes, then what is the appropriate penalty, if any, under the circumstances? This third question is answered by reference to the factors listed in Section 2695.12.

A. Does The Conduct At Issue Constitute An Unfair Trade Practice Defined In Section 790.03(h)?

Not all violations of insurance laws are "unfair trade practices" as that term is understood in insurance regulation. Historically, the drafters of the NAIC model laws sought to limit the unfair trade practice laws to certain problematic conduct as identified in advance by the legislature or the regulator. California's approach is consistent with these model laws. The vast majority of violations alleged in this case are not, in my opinion, unfair trade practices under California law and are not subject to the penalties in Section 790.035. The statutes governing the late payment of healthcare claims, provider acknowledgements, notice of the right to an independent medical review, and notice of the right to CDI review for contested or denied claims are not unfair trade practices laws. The California Legislature did not designate those provisions as unfair trade practices and CDI has not followed the procedure in Section 790.06 to declare violations of those provisions to be unfair trade practices. Violations of Sections 10133.66, 10123.13 and 10169 are not, by their own terms, unfair trade practices as that term is used in insurance regulation. Conduct not specifically defined by law to be unfair trade practices cannot form the basis of penalties under Section 790.035.

Significantly, CDI failed to use the procedure in Section 790.06 that would have permitted CDI to put the industry on notice that certain conduct would be prohibited as an unfair trade practice. Because many insurance laws predate current products and technology, Section 790.06 gives CDI and other regulators the ability to adjust regulations to recognize those developments and prescribe or proscribe certain conduct on a prospective basis. CDI, however, did not adopt regulations or avail itself of the Section 790.06 procedure for designating violations of certain insurance code sections to be unfair trade practices. Insurers (including

PacifiCare) were not on notice that violations of Sections 10123.13, 10169 or 10133.66(c) would be treated as unfair trade practices under Section 790.03(h) by CDI.

B. Does The Challenged Conduct Implicate A General Business Practice?

If, in fact, the conduct at issue is found to be an unfair trade practice, the next question is whether it constitutes a general business practice of the company. CDI's effort, through Mr. Cignarale, to hold PacifiCare to a standard of perfection is not consistent with what regulators do. Typically, regulators do not initiate enforcement proceedings to impose penalties for each noncompliant act of an insurer when there is no indication that the noncompliance is sufficiently pervasive so as to reflect a business practice of engaging in such non-compliant behavior. Insurance regulators throughout the country, including CDI, accept and rely upon tolerance thresholds to distinguish between noncompliance that is the result of inevitable human and system imperfections and noncompliance that has, instead, become the regular way in which an insurer conducts its business or a particular part of its operations. I have seen nothing in this case to justify a deviation from that standard. This case involves typical claims handling issues that CDI has dealt with in other matters without initiating an enforcement action to impose a penalty for every noncompliant act.

In assessing whether a general business practice exists, a regulator typically looks at what percentage of the time noncompliance occurs in the particular population. Section 790.03 and the NAIC Market Regulation Handbook provide guidance as to what constitutes a general business practice. States like California that have adopted the "with such frequency to indicate a general business practice" language of the NAIC Unfair Trade Practices Act and the Unfair Claim Settlement Practices Act are "strongly encourage[d]" to use the Handbook's benchmark error rate (7% for claims, 10% for non-claim acts) to determine when a violation of the state's unfair claim and trade practices acts has occurred. The Handbook describes the benchmark error rate as "a threshold used to establish the legal presumption of a general business practice." (NAIC Market Regulation Handbook, Chapter 14-D (2011 Edition). These benchmarks are not used just for sampling purposes. If non-compliance falls with the tolerance thresholds described above, a regulator can take comfort that the non-compliance does not rise to the level of a general business practice.

The issues with the IMR language on EOBs and information about CDI review on EOPs require a slightly different analysis to determine whether PacifiCare engaged in a business practice. These forms are templates that are system-generated and the analysis should be different than that of a deliberate decision that is made over and over again. The boilerplate language of the forms will be the same for all claims for which that form is generated. However, the decision about what information to include or exclude on a form was made only one time -- when the particular form was created -- despite the possible effect on multiple claims.

C. What Should Be The Appropriate Penalty Be, If Any, Applying The Factors In Section 2695.12?

For any business practices that are violations of the unfair trade practices laws, Section 790.035 prescribes the maximum amount of the penalty. This maximum applies regardless of whether the matter was settled or went to hearing. Section 2695.12 prescribes the process CDI is to use in considering *whether* to impose a penalty for unfair trade practices and, if so, the amount

of any such penalty. The fourteen factors listed in Section 2695.12 serve two purposes. The regulation provides that the Commissioner is to consider those factors in determining "whether to assess penalties" at all. If, after applying those factors, the Commissioner determines that a monetary penalty is warranted, the regulation directs the Commissioner to apply the factors to determine the appropriate amount of the penalty. These factors are similar to the considerations regulators in other states, including Ohio, generally apply, even when specific factors are not required by law.

In making a penalty determination, a company's overall performance should be considered rather than reviewing individual "buckets." To consider certain acts in isolation and out of context will not provide a complete picture of the company's conduct. The following discussion presents, in my view, a reasonable application of each factor to PacifiCare's conduct at issue in this case. Each relevant factor in Section 2695.12(a) is separately analyzed in light of the specific facts of this case. (Factors 2, 4, 5 and 6 have been excluded because they only apply to suspicious or fraudulent claims, which are not at issue here.)

1. Section 2695.12(a)(1): The existence of extraordinary circumstances.

The mandate to take into account the existence of extraordinary circumstances appears to authorize consideration of unusual or unique events. Based on my review of excerpts of testimony, including that of CDI's integration expert, Ronald Boeving, it does not appear that many, if any, of the alleged violations resulted from the PacifiCare/United integration. To the extent any alleged violations did, in fact, result from integration activities, I believe the exceptional circumstances of the enormous merger warrant consideration under this factor. Moreover, although the early termination of the CTN network apparently did not affect PacifiCare's overall claims handling, the termination was a unique event that had a disruptive effect on the manner in which PacifiCare was viewed by the California provider community, which as I note above, appears to have led, in part, to CDI's actions against PacifiCare.

2. Section 2695.12(a)(3): The complexity of the claims involved.

Health care claims are more complex than claims arising in most other lines of insurance. The processing, payment and contracting issues are much more complicated, involving in-network and out-of-network providers (including physicians, hospitals, labs, free-standing surgical facilities and others) that are paid based upon a extensive system of diagnosis and treatment codes for which specific fees are established. The sheer volume of claims adds to the complexity of a health insurer's systems and processes. When one considers simply the number of healthcare claims an individual might typically submit in a year compared to the number of other claims they might file (automobile insurance or homeowners' insurance) one can appreciate the volume disparity.

In my view, CDI and Mr. Cignarale do not give sufficient weight to this factor. When asked whether there are meaningful distinctions in assessing health insurance as compared to other lines of insurance, such as property and casualty insurance, Mr. Cignarale replied that there

are not meaningful distinctions for purposes of assessing performance and penalties. I disagree.[2] The inherent complexity and sheer volume of health insurance claims should be considered when assessing the alleged violations in this proceeding. I also saw evidence that particular aspects of PacifiCare's claims and contract operations were complex, including its transition of manual operations to automated processes.

This complexity means that a standard of perfection is not realistic. It also means that PacifiCare's performance should be viewed in relation to other insurers. The evidence I reviewed showed that PacifiCare had error rates consistent with other insurers and within tolerance thresholds typically accepted by regulators.

3. Section 2695.12(a)(7): The relative number of claims where the noncomplying act(s) are found to exist, the total number of claims handled by the licensee and the total number of claims reviewed by the Department during the relevant time period.

The volume and the complexity of healthcare claims is one important reason why individual errors should not be penalized when it is shown that the general business practice of the insurer is to process and pay claims in accordance with state law. Mr. Cignarale ignores the part of this factor which requires consideration of the total number of claims handled by the licensee. This part of the factor demonstrates that CDI recognizes and the law requires that the number of violations found must be compared to the volume of the claims processed by the insurer (or the number to the size of the sample when sampling is used). This is extremely important. The use of the tolerance thresholds as established by state regulators in the NAIC Market Regulation Handbook support this approach.

In that vein, in comparing PacifiCare to other insurers, Mr. Cignarale improperly focuses on the raw number of cited violations without taking into consideration how many claims of those other insurers were actually sampled and without trying to estimate how many alleged violations there would be based on the total population of claims for those other insurers. Mr. Cignarale admitted that neither he nor CDI made any effort to ascertain and compare PacifiCare's conduct and performance with other insurers during the same approximate time period for the same types of statutory violations alleged here. Significantly, CDI could have done so if it wanted. CDI's failure to undertake even a rudimentary comparison of PacifiCare's performance with other insurers during the same time frame makes it very difficult to accept Mr. Cignarale's proposition that PacifiCare's conduct was especially egregious and worthy of substantial penalization. Indeed, there is evidence to suggest that the conclusions would be far worse for those other companies if CDI had used the same approach.

4. Section 2695.12(a)(8): Whether the licensee has taken remedial measures with respect to the noncomplying act(s).

To further the insurance regulator's goal of protecting consumers, insurers that respond to regulatory concerns and take meaningful remedial measures are given credit for such actions. I

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[2] It is understandable that CDI staff might not have as much experience with health insurance as compared to other insurance departments because a major segment of the California heath insurance market is regulated by DMHC, a separate state agency.

gave such credit to deserving insurers as a regulator. Indeed, regulators often publicly encourage insurers to proactively address compliance issues. Not recognizing PacifiCare's proactive efforts to address compliance issues creates a counterproductive regulatory climate.

Significantly, CDI admits that PacifiCare remediated all of the issues in this case some time ago. This is not a case in which the regulator had to order an insurer to comply or to reprocess claims. Mr. Cignarale was not aware of any changes that were needed or any claims that needed to be corrected. Of further significance to me is the fact that in addition to changing and improving its procedures, PacifiCare also initiated various projects to review, rework and make additional payments on claims that may have been impacted. While Mr. Cignarale acknowledges that there was no corrective action left undone, he suggests that some remedial measures did not occur fast enough or were not sufficient in some way. It is significant that CDI is criticizing certain actions when, at the time, it appears that CDI did not offer any specific steps the company should take. Further, rather than give PacifiCare significant credit for voluntarily remediating the issues underlying the alleged violations, CDI appears to cite PacifiCare's remedial and corrective actions as evidence against PacifiCare to support CDI's litigation position. That does not seem appropriate to me.

Mr. Cignarale testified that CDI was not getting the level of cooperation it expected, but admitted that he formed that impression based upon certain communications with his staff. The testimony of his staff, however, shows that PacifiCare never objected or refused to provide information, never refused to undertake any conduct requested of them, and was responsive and took issues seriously. The question should not be whether perfect decisions were made on each and every occasion. While ideal, that is hardly realistic. The issue should be whether PacifiCare responded reasonably to remediate any potential issues.

5. Section 2695.12(a)(9): The existence or nonexistence of previous violations by the licensee.

There is no evidence in this case that PacifiCare had any prior violations of any kind in California. That reflects favorably on the company. Mr. Cignarale confirmed that prior to the acquisition PacifiCare "did not have a record of significant previous violations." However, he refused to give credit to PacifiCare for the lack of prior violations because he apparently thought it would inure to the benefit of United, an entity that is not the respondent in this case. In my view, the prior conduct of respondent and the lack of previous violations or enforcement actions is a significant mitigating factor.

6. Section 2695.12(a)(10): The degree of harm occasioned by the noncompliance.

While the factors in 2695.12 are not ranked in terms of importance, regulators tend to be most concerned with the harm caused by an insurer's noncompliance. The kinds of harm that most concern regulators are measurable monetary losses such as claims that are not paid and policy benefits that are not provided. This type of harm is real and measurable. Significantly, there was relatively little harm of that sort in this case, particularly when one considers the breadth of the exam and the scope of operations at issue -- and any harm has been remediated. Moreover, the total amount of payments in the various claims rework projects -- on of the few areas involving a quantifiable monetary impact -- is relatively small when one considers the total dollar value of claims that PacifiCare processed in the same period.

Indeed, most of the alleged violations at issue in this case involve routine claims handling and notice issues that one sees fairly often in conducting market conduct examinations. Though Mr. Cignarale emphasizes the raw number of alleged violations as evidence of the greater harm here, that number in and of itself does not have much meaning, particularly where CDI has not conducted a similar analysis of other insurers. Indeed, given the number of claims that CDI reviewed, it is significant that so little quantifiable harm was found.

Other recent enforcement actions involving health insurers involved far more significant and quantifiable harm even though the number of alleged violations may have been smaller. Concurrently with this action, and excluding its settlement with United, CDI managed several "high profile" matters which implicated far greater harm and involved allegations of improper rescissions of health insurance policies. A rescission of health coverage creates a coverage lapse, which impairs the member's ability to obtain new coverage and can cause the member to become subject to pre-existing condition exclusions and expose them to having to repay claims that had been paid by the insurer prior to the rescission.

Similarly, more troubling conduct was at issue in cases involving annuities and disability income policies. According to the Commissioner, Allianz Life Insurance Company of North America caused significant monetary harm to a vulnerable population -- senior citizens. After an examination of annuity sales made by Allianz to seniors aged 84 and 85, the Commissioner determined that 97% of the sales were unsuitable, that deceptive marketing had been used, and that, as a result, senior citizens incurred surrender charges of up to $51,000 each and the potential for additional surrender charges on the new annuities. This is an example of serious, out of pocket monetary harm to a vulnerable population.

CDI entered into a settlement with three Unum companies that involved allegations that the insurers were improperly denying or halting disability income benefits to disabled people by using improper claims handling techniques, improperly applying policy provisions, selectively using certain medical information and ignoring other relevant information, and mischaracterizing certain disabling conditions, among other allegations. The harm CDI alleged resulted from Unum's conduct was severe as it affected disabled beneficiaries whose health conditions prevented them from earning a living. The impact and lasting effect of a denial of disability income benefits far exceeds whatever harm may have resulted from any conduct at issue here.[3]

Mr. Cignarale frequently mentioned the *potential* for harm. It is certainly something to consider with regard to the allegations of improper claim denials, but more difficult to see in the context of the alleged failure to comply with 10133.66(c), the form EOP and EOBs or even the late pays where providers are paid at a significant rate of interest. In this case, however, it does not seem appropriate to give this hypothetical risk much weight where there is almost no evidence of harm or injury despite years of investigation, consumer complaints, an apparent close relationship with the CMA, a highly public enforcement action and continued access to company records. The only evidence of harm involves dollars that were uncovered in connection with the market conduct exam, many of which were discovered by PacifiCare. I

[3] This comparative assessment of harm does not even consider the additional harm in these other enforcement actions associated with claims handling issues of the type that are involved in this case.

looked in particular for any allegations that member care was deferred or instances where a member's health had deteriorated and found no such instances. While CDI initially contended that Mrs. W's son was denied treatment as a result of conduct by PacifiCare, a review of the files of Mrs. W made clear that her son was denied treatment through the acts of another insurer entirely. Also significant is the fact that members have grievance rights when they believe a claim was not paid or handled appropriately. It is very possible that any such person who needed treatment would have exercised their right to file a grievance with PacifiCare and resolved the issue through that mechanism. While the right to a grievance would not excuse any actual non-compliance, the exercise of that right would have provided PacifiCare with an opportunity to review the issue and may have eliminated the potential for harm.

I disagree with Mr. Cignarale that PacifiCare's actions have caused harm to the regulatory process and with his statement that any violation of law harms the regulatory process. When I think of the term "regulatory process," I think of the system of insurance regulation, the insurance laws and the regulators who are charged with monitoring the industry and enforcing insurance laws. That regulatory process is at work in this case, from CDI's handling of complaints through its prosecution of PacifiCare in this hearing. The fact that a regulated entity may have violated an insurance law does not cause harm to or disrupt the regulatory process – the regulatory process is designed to respond to those circumstances. Based upon my experience, harm to the process would involve, for example, a refusal of a licensee to comply with a regulator's demands or fraud or deceit in the licensee's dealings with its regulator. Harm to the regulatory process might arise if an insurer submitted fraudulent financial statements or refused to make its books and records available to the regulator upon request, or if a licensee refused to comply with a lawful order issued by the regulator. Such obstructive or deceitful conduct could prevent a regulator from performing its duty and interfere with the regulatory process.

My review of the record in this case does not cause me to conclude that PacifiCare sought to obstruct the investigation or to "hide the extent of its non-compliance" as Mr. Cignarale suggests. To the contrary, PacifiCare cooperated from the outset, was candid about operational issues it was facing, and went to great lengths to appease CDI and conform itself to the positions CDI was taking. Though Mr. Cignarale refers to alleged efforts to conceal the fact that provider acknowledgement letters were not being sent during the period under investigation, in my opinion, the record reflects general confusion around the issue, not an effort to mislead. I saw nothing that evidenced an intent to mislead or deceive CDI.

I also believe that CDI's own conduct contributed to some of the confusion between the parties. For example, I believe that had CDI had an open dialogue with PacifiCare concerning its interpretation and expectations under Section 10133.66(c), many of the issues that arose could have been avoided.

7. Section 2695.12(a)(11): Good faith attempt to comply.

I have seen no evidence that PacifiCare did not want or try to comply with the insurance laws. The evidence indicates a company that tried to comply, had policies and procedures in place, that reviewed and measured its performance, that changed its procedures both to improve performance and in response to identified issues. PacifiCare paid attention to new laws and implemented them based on what it believed were compliant practices. The evidence also

indicates that those procedures and controls were being continuously improved. Regardless of whether PacifiCare's performance was 100% perfect, the company demonstrated the requisite concern for compliance and acted accordingly. This is to be encouraged and PacifiCare's good faith efforts to be compliant should be considered a mitigating factor.

8. Section 2695.12(a)(12): The frequency of occurrence and/or severity of the detriment to the public caused by the violation.

This factor requires assessment of the alleged violations in context. A figure for the frequency of violations is not meaningful without knowing the circumstances of how the frequency of violations is calculated.

Here, as discussed in more detail elsewhere, CDI applied to PacifiCare examination techniques that have not been applied to any other insurer. That fact, by itself, makes it unfair and misleading to compare the number of violations alleged in this case with other examinations Further, CDI has focused on the simple number of alleged violations without considering the number of claims handled by PacifiCare or examined by CDI. The same frequency would be expected for any health insurer As to late paid claims, as noted, PacifiCare's performance was well within thresholds established by regulators and the Undertakings. In my view, when the volume and the nature of compliance issues in this case is compared to that of other insurers, it does not appear to be unusual. I also found, as discussed above, relatively little harm that may have resulted from PacifiCare's actions in this case.

9. Section 2695.12(a)(13): Whether the licensee's management was aware of facts that apprised or should have apprised the licensee of the act(s) and the licensee failed to take any remedial measures.

The evidence in this case that I have seen indicates that upon discovery of potential noncompliance PacifiCare and its management reacted by developing procedural, staffing, operational and/or systems changes to come into compliance and to improve the company's performance. Even when the company disagreed with CDI's interpretation of a law, PacifiCare took actions to comply with its regulator's demands. Based on Mr. Wichmann's testimony the directive to be compliant came from the top of the organization, as it should.

D. Summary of Penalty Factors

The conduct and violations alleged here, when placed in the proper context, involve a number of routine market conduct exam issues and are much less egregious or harmful than what I have seen in those cases where CDI has imposed significant penalties. Further, the penalty (if any) should certainly not be in excess of penalties historically assessed by CDI, and given the relative harm here as compared to other enforcement actions, should be less than any of the significant ones.

APPENDIX A

SUSAN T. STEAD

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PROFESSIONAL EXPERIENCE

Over 20 years of experience in insurance regulation.

Partner, Nelson Levine de Luca & Horst, LLC (2005 – present)
Partner and Chair of the Insurance Regulatory practice group. Counsel insurance companies and others in the insurance industry on regulatory and business requirements, compliance and risk reduction. Represent insurers in regulatory inquiries, investigations, examinations, self-reporting and in obtaining regulatory approvals. Provide compliance risk assessments, develop compliance policies and procedures, analyze policyholder communications and policy forms for compliance, assist insurers and others with licensing and registration requirements, conduct compliance and claims audits and provide legislative lobbying services.

Assistant Director, Ohio Department of Insurance (1999-2005)
Policy level position overseeing three divisions of state insurance department including Market Conduct, Fraud & Enforcement and Agent Licensing, a staff of over 50 and budget in excess of $5 million. Chaired and participated in several committees of the National Association of Insurance Commissioners concerning market conduct and licensing issues.

Developed and implemented a market analysis program, led efforts to streamline market conduct exams among states, chaired the committee that developed the NAIC's Market Conduct Annual Statement, implemented national uniformity standards for market conduct examinations and risk focused market analysis. Conducted state's first prompt payment data call and analysis for healthcare claims and instituted an electronic provider complaint system. Initiated state's first market conduct examinations of life insurers, credit insurers and HIPAA issues.

Simplified agent licensing process by introducing electronic applications, fingerprinting and other electronic services, eliminated bureaucratic processes and reduced licensing time from six months to 7-10 days.

Established triage system and performance measures for investigative units.

Developed department policy and worked with legislators to amend laws on prompt payment of healthcare claims, agent licensing, bail bond agent regulation and viatical settlements.

Staff Counsel, Ohio Department of Insurance (1990 – 1999)
Provided legal advice and support to investigative divisions of state department of insurance; initiated administrative actions on behalf of agency; participated in investigations, reviewed mergers, acquisitions, certificate of authority applications and other transactions requiring regulatory approval. Provided legal advice to other divisions on regulatory requirements, including marketing, rating issues, new products, cancellation/nonrenewal procedures, claims issues and licensing matters. Drafted agent licensing legislation and related regulations. Conducted investigations involving employment matters.

Associate, David L. Day, LPA (1985-1990)
Insurance defense practice, including insurance agent errors and omissions claims.

Associate, Morton, Hessler & Derr (1984-1985)
General business and litigation practice.

EDUCATION

1984 J.D. Ohio State University Moritz College of Law
1980 B.A. (Political Science) Wittenberg University

PROFESSIONAL DESIGNATIONS

Chartered Property & Casualty Underwriter
Market Conduct Manager (MCM)

PROFESSIONAL ACTIVITIES

IRES Foundation Board, Vice Chair
American Bar Association Insurance Regulation Committee, Past Chair.
Association of Insurance Compliance Professionals, Member.
Columbus Bar Services Agency, Inc. Board of Directors, Chair.

PRESENTATIONS

- *Insurance and Social Media: Legal and Regulatory Risks,* National Association of Mutual Insurance Companies (NAMIC) Webinar, November 21, 2011.
- *Social Media: Legal and Operational Risks,* American Insurance Association (AIA), November 8, 2011.
- *Compliance and E&O Risks of Using Social Media,* CPCU Society, October 18, 2011.
- *Not Your Parents' Market Conduct* (Moderator), Association of Insurance Compliance Professionals (AICP) 2011 National Meeting, September 28, 2011.
- *The Future of Market Conduct Annual Statement, (MCAS)* (Moderator), Association of Insurance Compliance Professionals (AICP) 2011 National Meeting, Moderator, September 27, 2011.
- *Enterprise Risk Management* (Moderator), IRES Foundation National School on Market Regulation, April 11, 2011 - April 12, 2011.
- *Working with Agents and Brokers: Conducting Effective AML Training and Improving Communications Between the Parties.* ACI Conferences (2011).
- *Before the Breach - What You Need to Know and Do to Be Prepared,* Wolters Kluwer Financial Services Strategic Advisory Board (2010).
- *Insurance Meets the World of Social Media* (Moderator), Insurance Consumer Affairs Exchange (2010).
- *State Spotlight Session - Minnesota/Florida and L&H: FINRA/SEC and the Impact on DOI's Ability to Regulate* (Moderator), IRES Foundation - The National School on Market Regulation (2010).
- *Legal Authority and Issues in Financial Risk Examinations,* Property Casualty Insurers Association (2009).
- *You Want It Kept Confidential?* IRES Foundation – The National School on Market Regulation (2009).
- *Insurance Advertising Best Practices,* OAMIC/OII/B&E Fall Seminar (2008).
- *Think You're in Compliance? - Market Conduct Preparation and Advertising Requirements and the Compliance Review Process,* Association of Insurance Compliance Professionals (AICP) (2008).
- *Market Regulation Roundtable,* Insurance Regulatory Examiners Society (2008).
- *State Regulation of Insurance Advertising,* Property Casualty Insurers Association (2008).

- *Internal and External Investigations: Attorney-Client Privilege and Other Legal and Ethical Issues,* ABA's Emerging Litigation and Regulatory Developments in Insurance Law - A Symposium (2007).
- *Confidentiality and Self-Evaluation Privilege Laws - 2007: License to Learn,* National Association of Insurance Commissioners (2007).
- *When Bad Things Happen to Good Companies,* Securities and Insurance Licensing Association, (2007).
- *I've Performed My Due Diligence, Now What?* Property Casualty Insurers Association (2007).
- *For Your Eyes Only – Exchanging Information with State Insurance Regulators in the Context of Internal and External Investigations,* American Bar Association/American Insurance Association Seminar (2007).
- *Regulator Relationships,* Association of Insurance Compliance Professionals Midwest Chapter (2007).
- *Getting to the Truth: Attorney/Client Privilege, Ex Parte Communications, Undercover Investigations and Other Legal and Ethical Issues that Arise in Fact Investigations*, American Bar Association Annual Meeting (2006).
- Panelist: *The Market Conduct Annual Statement*, ACLI Annual Compliance Meeting (2006).
- *Data Collection for Market Analysis*, National Association of Insurance Commissioners E-Regulation Conference (2006).
- *What Are Your Legal, Ethical and Regulatory Responsibilities?*, Insurance Board of Northern Ohio (2006).
- *The SMART Act*, Securities & Insurance Licensing Association (2005).
- *Market Conduct Annual Statement*, NAIC Market Analysis Training (2004).
- *Market Conduct Annual Statement*, NAIC E-Regulation Conference (2004).
- *Regulators, Get Off My Back* and *Market Conduct Modernization*, IRES Foundation National School on Market Regulation (2004).
- Various insurance topics and updates, Ohio Association of Insurance and Financial Advisors (2002, 2003, 2004).
- *Cooperative Market Conduct Exams – Do They Work?*, Insurance Consumer Affairs Exchange (2003).
- *Gramm-Leach-Bliley Act* and other producer licensing and regulatory topics, Midwest Chapter of the Society of Insurance Licensing Administrators (now the Securities & Insurance Licensing Association) (2001, 2002).
- *Market Conduct Reform Initiatives*, American Insurance Association Compliance Issues Subcommittee (2002).
- Panelist: *NAIC Market Conduct Activities*, American Council of Life Insurers Compliance Section (2002).
- *Prompt Payment of Healthcare Claims in Ohio and External Review Update*, Ohio State Bar Association Health Care Law Seminar (2002).

PUBLICATIONS

"Social Media and Surplus Lines" *National Underwriter*, (August 2010).

'Social Media Meets Insurance Regulation: Where are We Headed?" *National Underwriter*, (June 2010).

"NARAB II - The Devil's in the Details - The Practical Effects of HB 2554 on Insurance Regulators and the Industry" *Federation of Regulatory Counsel, Inc. (FORC), Journal Vol. 21 Edition 2 - Summer 2010.*

"Why Public Adjuster Laws Do Not Apply to Field Services Companies", MortgageOrb.com (May 2010).

"Attorney-Client Privilege and Confidentiality Issues in Internal and External Investigations" *American Bar Association The Brief* (Summer 2006).

PROOF OF SERVICE

I, Deborah Waterford, hereby declare: I am employed in the City and County of San Francisco, California in the office of a member of the bar of this court at whose direction the following service was made. I am over the age of eighteen years and not a party to the within action. My business address is SNR Denton US LLP, 525 Market Street, 26th Floor, San Francisco, California 94105. On January 27, 2012, I served:

EXPERT REPORT OF SUSAN T. STEAD

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

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

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

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

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

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

EXECUTED on January 27, 2012, at San Francisco California.

Deborah Waterford

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