Expert Opinions of Susan Stead

I. Summary

II. Qualifications

III. Fundamental precepts relating to insurance regulation

IV. CDI's arbitrary and subjective approach

V. Regulators should be fair and impartial

VI. Analyzing insurer conduct under §790.03(h) and §2695.12

Key Qualifications

- **14+ years as insurance regulator.**
  - For Ohio Department of Insurance.
  - 6 years in senior management with oversight over market conduct, fraud and enforcement, and agent licensing divisions.
  - Significant relevant experience in health insurance regulation.
    - Oversight of market conduct examinations of health insurers.
    - Actively involved in the development and implementation of legislation concerning processing of provider claims (akin to SB367, 634).
    - Developed a system of prompt pay data analysis and procedures for filing of complaints by providers.
- **National Association of Insurance Commissioners ("NAIC").**
  - Significant experience in working groups related to market conduct issues.
  - Continue to regularly attend meetings of NAIC.
- **Board member of IRES Foundation, which supports and funds education for insurance regulators and sponsors National School of Market Regulation.**

Key Qualifications

- **Chair, Insurance Regulatory Practice, Nelson Levine de Luca & Horst.**
- **Former Chair, Insurance Regulation Committee of the American Bar Association.**
  - Analyzed emerging issues in insurance regulation.
  - Advised ABA leaders concerning legislative initiatives.
  - Co-sponsored national conferences educating industry.
- **Relevant designations: Market Conduct Manager (MCM), Insurance Regulatory Examiners Society; Chartered Property & Casualty Underwriter (CPCU), American Institute for Chartered Property Casualty Underwriters.**
- **Additional relevant memberships: Federation of Regulatory Counsel; Association of Insurance Compliance Professionals.**

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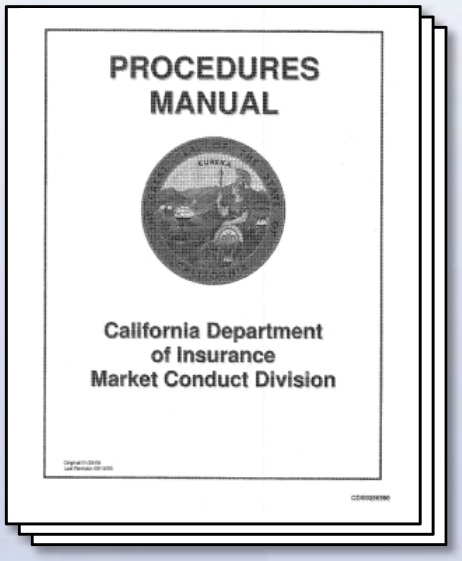
Objectives of Regulation

About Us: An Introduction to CDI Operations

(Revised February 2004) The 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://insurance.ca.gov/0500-about-us/0100-cdi-introduction/



Ex. 5407

Values

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

Mission

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

Forms of Notice Available to and Utilized by CDI

- **Educational initiatives.**
- **Bulletins and notices.**

STATE OF CALIFORNIA — Dave Jones, *Insurance Commissioner*

DEPARTMENT OF INSURANCE
Executive Office
45 Fremont Street, Suite 2300
San Francisco, CA 94105

NOTICE

TO: All Admitted Health Insurers and Other Interested Persons

DATE: May 17, 2011

SUBJECT: Enforcement of Independent Medical Review Statutes

Ex. 5624

STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
45 Fremont Street
San Francisco, California 94105

BULLETIN NO. 2011-2
April 11, 2011

TO: All Admitted Insurers and Other Interested Persons

SUBJECT: IMPLEMENTATION OF REINSURANCE PROVISIONS OF THE FEDERAL NONADMITTED AND REINSURANCE REFORM ACT

STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
45 Fremont Street, 23rd Floor, San Francisco, CA 94105

Bulletin 2007-2
January 3, 2007

TO: All Affected Life and Disability Insurance Companies and Other Interested Persons

SUBJECT: Implementation of AB 1586: Insurance Gender Non-Discriminatio

Return

CALIFORNIA
DEPARTMENT OF INSURANCE

INSURERS: NOTICE NOVEMBER 8, 2002

Recent Changes in the Law Affect Insurers Writing Automobile Liability Insurance in California

TO: ALL INSURERS WRITING AUTOMOBILE LIABILITY INSURANCE IN THE STATE OF CALIFORNIA

DATE: November 8, 2002

Forms of Notice Available to and Utilized by CDI

- **Formal rulemaking. *See* §790.10.**
- **Enforcement actions without penalty.** *See In the Matter of Blue Shield of California Life and Health Insurance Co.,* UPA-2011-00001, OAH No. 2011080142.
- **Procedure under §790.06.**
  - See *In the Matter of the Licenses and Licensing Rights of: Life Insurance Company of North America,* UPA-2008-00004, OAH No. (pending). (Ex. 5669)

NON FAIR CLAIMS SETTLMENT PRACTICE FINDINGS

32. As a result of the examination, the Commissioner, in his official capacity, now alleges that Respondent has violated, in addition to the provisions of the Fair Claims Settlement Practices Regulations above, the following and that these violations constitute acts or practices that are unfair or deceptive: the examiners identified five violations instances where

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Arbitrariness of Cignarale's Initial Penalty

- **Unprecedented.**
- **Contrary to applicable regulations.**
  - Application of §2695.12 factors ends rather than starts analysis.
  - No authority to create generic penalties.
  - Applies unspecified factors outside of §2695.12.
- **Designed by Cignarale for PacifiCare.**

Q. So this whole concept of a generic violation and assessing a dollar amount from which we then move up and down for PacifiCare, this whole construct is designed only for PacifiCare and this case, correct?

A. It's currently – was designed by me for PacifiCare.

12/7/11 Tr. 23230:9-14 (Cignarale)

Arbitrariness of Cignarale's Initial Penalty

- **No analysis to justify generic penalties.**
  - Did not discuss with anyone else at CDI.

> Q. To be clear, you didn't discuss with anyone other than counsel your philosophy on assigning these values for generic violations in each of these categories, correct?
>
> A. Correct.
>
> 12/7/11 Tr. 23228:16-20 (Cignarale)

  - Based on limited experience in health insurance regulation.

Arbitrariness of Cignarale's Recommended Penalty of $325 Million

- **"Q. …[I]t's a number that's just sort of based on some sort of sense of experience within the Department you thought was appropriate, correct? A. Yes."***
  - An extreme amount.
  - "Black box"
  - Irrespective of the magnitude of violations actually found, if any.
  - No reliance on prior penalties.

*12/7/11 Tr. 23177:16-20 (Cignarale)

Prior Actions Are Relevant

- The Commissioner has the same statutory obligation to enforce the laws and assess a penalty (where appropriate) whether action is settled or litigated.
- To ensure fairness and consistency, a regulator cannot view a licensed entity's conduct in isolation.
- The factors in §2695.12 apply equally to all enforcement actions brought involving claims handling violations under §790.03(h).
- Mr. Cignarale offers seemingly contradictory testimony on the issue.

Recommended Penalty Is Inconsistent With Other CDI Penalties

- **Grossly disproportionate to any penalty assessed ever.**
- **Nature and severity of alleged violations in other actions far more serious than what is alleged here**

	Nature of Conduct	Penalty Assessed	Restitution Paid
Unum	Denied disability benefits to 26,000 California residents	$8 million	>$50 million
Allianz	Misled elderly residents into purchasing unsuitable annuities	$3 million	~$100 million
Blue Shield	Rescission and claims handling	$0	Undisclosed
Blue Cross	Rescission and claims handling	$1 million	$14 million
Health Net	Rescission	$3.6 million	$22 million

- **Similar claims handling allegations at issue in Blue Cross, Blue Shield and PacifiCare.**
- **No change in regulatory approach toward assessment of penalties.**

Comparison of Claims Handling Issues: Blue Shield and PacifiCare

	Blue Shield	PacifiCare
§790.03 violations per sample claim file	1.81	0.27
Late pays	Yes	Yes
Failure to pay interest on late paid claims	Cited for significant non-compliance in prior exam report.	Not cited for significant non-compliance in prior exam report.
Errors in form EOBs	Yes	Yes
Examination recovery amounts	$1,035,962.37	$156,455.06
Rescission	Yes	No
Dollars paid in rescission	Not Reported	Zero
Failures to respond to a CDI inquiry within 21 days	175	30
Pre-Ex	Yes	Yes
	Penalty: $0	**Recommended Penalty: $325 M**

CDI's Contradictory Positions

- **Undertakings.**
  - Before: CDI said Undertakings defined an acceptable level of timely claims processing.
  - After: CDI said compliance with the Undertakings constitutes an unfair claims settlement practice.
- **Position with regard to what constitutes an unfair claims settlement practice.**
  - Before: CDI cited only 90 instances of unfair claims settlement practices.
  - After: CDI said all of the conduct at issue constitute unfair claims settlement practices.
- **Position with regard to the regulator's role in the day-to-day operations of insurers it regulates.**
  - Before: CDI was not interested in getting involved in PacifiCare's operational details.
  - After: CDI has criticized numerous aspects of PacifiCare's operational details.

CDI's Interpretation and Enforcement Of Particular Statutes

- **Interpretations at issue.**
  - Right of review language in EOPs.
  - Right to IMR in EOBs.
  - Acknowledgement letters for paper claims.
- **A reasonable regulator does not penalize an insurer that agrees to change its behavior where:**
  - The interpretations at issue do not closely track the statutory language.
  - The statutes and/or CDI's interpretations are new.
  - There is no written guidance.
- **Interpretations appear arbitrary and driven by increasing the number of alleged violations.**

CDI's Interpretation of Insurance Code §10123.13(a)

- **Newly enacted provision.**
- **Statute requires right of review language only in EOPs involving "contested or denied" claims.**
- **CDI found all claims non-compliant.**
  - Contradicts the plain meaning and usage (including by CDI) of "paid," "contested," or "denied."
  - Interpretation eliminates any meaning in the statute to the term "contested or denied."

CDI's Conflicting Interpretations of "Paid" and "Denied"

- **Before: Identified 1,125,707 claims as paid claims.**

PLHIC ELECTRONIC CLAIMS PAID REVIEW*

LINE OF BUSINESS / CATEGORY	NUMBER OF CLAIMS	CITATIONS
Accident and Disability / Group Health Claims Paid	1,077,024	101,720
Accident and Disability / Individual Health Claims Paid	48,683	27,129
Claims Paid	1,125,707	128,849

Ex. 1

- **After: Essentially treats all claims as contested or denied.**

* Includes paid claims with one or more denied claim lines.

CDI's Interpretation of Insurance Code §10169(i)

- **IMR statute makes no reference to EOBs.**
  - EOB is a term of art within the health insurance industry.
  - Legislature has utilized the term.
- **CDI never before cited PacifiCare for failing to include IMR language in the EOB.**
- **No evidence of CDI enforcement against largest PPO insurers either.**
- **CDI's conduct undermines its assertion of significant harm.**

CDI's Interpretation of Insurance Code §10133.66(c)

- **Newly enacted provision.**
- **Plain language of the statute does not appear to support CDI's interpretation.**
- **Health plans had been operating under DMHC's interpretation for years.**
- **Legislative history supports application of DMHC interpretation.**
- **CDI's conflicting interpretation is contrary to its stated objective of consistency with DMHC on legal issues, public policy matters and enforcement activities.**

Material Deviations from CDI Procedures Are Evident in the Record

- **Disavowing the relevance of the NAIC Handbook.**
- **Failing to adequately maintain documents related to this matter.**
  - Testimony of CDI witnesses:
    - Nicoleta Smith: Destroyed documents.
    - Robert Masters: Admitted CDI lost numerous PacifiCare complaint files.
    - Joel Laucher: Disregarded CDI manual regarding document retention.
  - Declaration of Samer Alami: No electronic document retention procedures in practice and no litigation hold for the case.
- **Disregarding CDI jurisdiction.**
- **Failing to require providers to exhaust PacifiCare's internal appeals process.**

The Deputy Commissioner's View On CDI's Retention Policies

THE COURT. … But, Mr. Cignarale, I guess my interest is does anything about that Paragraph 8 concern you?

A. No, your Honor, nothing – it doesn't concern me. I would say there is a distinction between what's contained in Paragraph 8 and the officers' putting into the complaint file the relevant information that they feel should be maintained, either the hard copy of the file or the electronic version of the file, whether that be copying an e-mail into the electronic version of the file with log notes or printing off a copy of something that they feel pertained to that file and it's relevant. So I really think that there are two distinct issues.

12/19/11 Tr. 24106:1-13 (Cignarale)

CDI's Conflicting Interpretations of "Paid" and "Denied"

- **Before: Identified 1,125,707 claims as paid claims.**

PLHIC ELECTRONIC CLAIMS PAID REVIEW*		
LINE OF BUSINESS / CATEGORY	NUMBER OF CLAIMS	CITATIONS
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Accident and Disability / Individual Health Claims Paid	48,683	27,129
[illegible]s	1,125,707	128,849

Claims Paid

Ex. 1

- **After: Essentially treats all claims as contested or denied.**