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

"How We Got Here" Can Matter

- **Regulators are given discretion in enforcing the insurance laws.**
- **That discretion can be abused in material ways that can affect the number and type of alleged violations at issue. For example:**
  - Developing new and unannounced interpretations of statutes and regulations.
  - Looking at entire claims population instead of just a sample.
- **CDI acknowledges the importance of objectivity.**

Apparent Bias Toward Provider Interests

- **Loss of CTN and the provider recontracting effort caused influential providers to actively lobby CDI to take action against PacifiCare and/or United.**
- **Undue coordination of investigation, examination and enforcement action with California Medical Association.**

-- "I am confident that you all at CMA will be pleased with the direction we are heading . . . ." (Ex. 5413)

-- "[T]he more numbers racked up, the better." (Ex. 5413)

-- "Partly as a result of your teachings and influence, I have gotten the CDI to expand their scope…" (Ex. 5414)

-- "Looks like you uncovered a gold mine of additional violations." (Ex. 5512)

-- "We'll rework our 'wish list.'" (Ex. 5415)

- **Special rules for CMA and other "VIP" complainants outside of complaint process and/or outside jurisdiction.**

Unprecedented Lack of Objectivity In Public Statements of Commissioner

- **"[A]fter years of broken promises to Californians, it is crystal clear that PacifiCare simply can not or will not fix the meltdown in its claims paying process. We're going to put an end to that."**

  (Ex. 5272, Commissioner Steve Poizner press release, January 29, 2008)

- **"The integration of PacifiCare was botched…[t]hat ended up creating a horrible situation for policyholders and doctors to deal with this company."**

  (Ex. 5391 at Ex. B, CDI spokesperson Ioannis Kazanis, September 8, 2010)

Why Relevant Today?

The exam was conducted, enforcement action was brought, and CDI's positions were formed during the period of questionable conduct by the Commissioner and certain staff.

EOB and EOP Citations Illustrate Apparent Bias

- **Prior to the spring of 2007, CDI did not cite PacifiCare for allegedly non-compliant EOBs or for failing to include "right of review" language for paid claims. (Exhs. 5694-6).**
- **Citations began during the period of significant provider activity.**

2007	
January	0
February	0
March	1
April	25
May	0
June	13
July	8
August	31
September	34
October	24
November	2
December	0

EOB – IMR Lang.

3/29/07: First Cited Violation of 10169i.

Exh. 5686

2007	
January	1
February	7
March	72
April	89
May	249
June	57
July	82
August	92
September	52
October	36
November	28
December	3

EOP – Right of Review Lang.

2/28/07: First Cited Violation of 2695.7b3 for a paid claim.

Exh. 5690

- **During the hearing CDI added a separate violation for every allegedly non-compliant form.**

Genesis of First IMR Citation (Paid Claim Involving "Special Complainant")

- **First file cited does not even arguably implicate the right to an IMR.**
- **File cited involved a "special complainant" whose file had been closed a month prior.**

11/28/06
Complaint filed by Michael and Kim Griffin over the amount of money paid pursuant to the negotiated contract. (Ex. 302)

2/21/07
CDI closes file stating "there is a difference of opinion between you and the insurance company that this Department . . . does not have the authority to decide." (Ex. 5651)

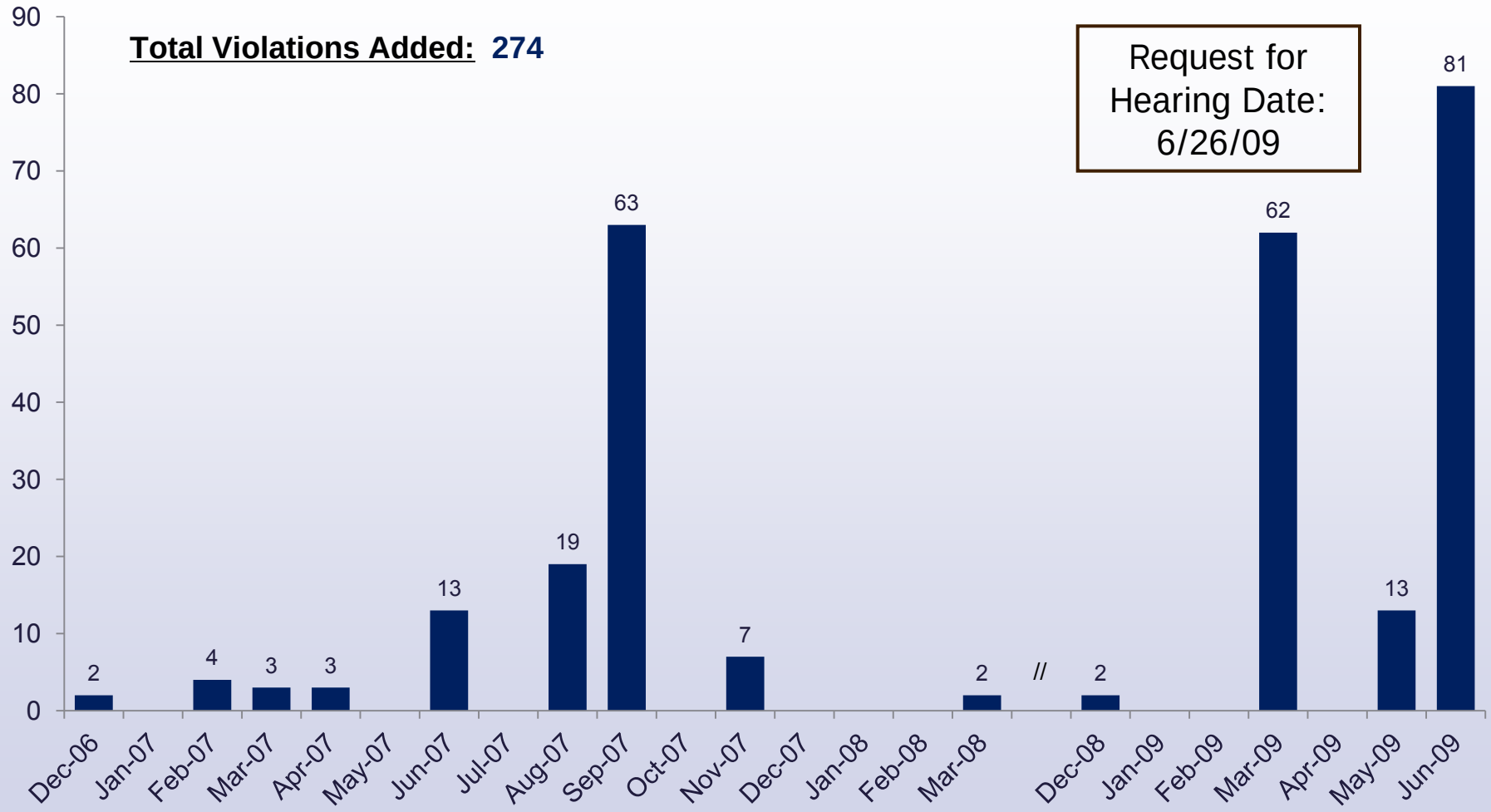
3/13/07
Senator Yee's office forwards complaint to CDI on behalf of Griffins. (Ex. 5684)

3/23/07
CDI re-opens the complaint file and requires weekly updates to Commissioner. (Exs. 5684, 5685, 5687)

3/29/07
CDI issues new complaint letter citing PacifiCare under §10169(i) (Exs. 37, 5686)

2006 | **2007**

Alleged Violations by CDI After Initial Complaint Closing



(Includes Complaints Opened from12/19/05 – 1/25/08 and Complaints alleged after 1st Supplemental Accusation)

Expert Opinions of Susan Stead

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

A. **Does The Conduct At Issue Constitute An Unfair Claims Settlement Practice Defined In §790.03(h)?**

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

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

No Unfair Claims Settlement Practices At Issue

- **California's Unfair Practices Act is not unique.** The Act is based upon the NAIC Unfair Claims Settlement Practices Act (the "NAIC Model Act") implemented by the vast majority of states including Ohio, Texas, California, New York and Florida.

- **Conduct at issue governed by statutory schemes separate from Unfair Practices Act.** California and other states subsequently recognized the need to implement statutes specific to health insurance claims handling like California's SB634 and SB367.

Prohibited Conduct Is Largely the Same

NAIC Model Act, § 4	Cal. Ins. §790.03(h)
A. Knowingly misrepresenting to claimants and insureds relevant facts or policy provisions relating to coverages at issue;	**(1)** Misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.
B. Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies;	**(2)** Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.
C. Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;	**(3)** Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.
G. Failing to affirm or deny coverage of claims within a reasonable time after having completed its investigation related to such claim or claims;	**(4)** Failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured.
D. Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;	**(5)** Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

CDI Reported §790.03 Violations Consistent With Its Limited Application

- **Statutory obligation to publish violations of §790.03 in market conduct exam report.**
- **Reported 90 violations of §790.03 in CDI's public report of the PacifiCare market conduct exam.**

> Q. So at the time you prepared the Report you did not view them to be violations of 790.03?
>
> * * *
>
> THE COURT: It seems to me that the answer needs to logically be yes. But I haven't heard an answer, so I am going to allow the question.
>
> A. Correct.
>
> 9/16/10 Tr. 11583:22 – 11584:5 (T. David)

- **Legal and senior management approved the report.**
- **At hearing, CDI examiner Coleen Vandepas amended the public report to include only two additional §790.03 violations**

PacifiCare Market Conduct Exam -- Public Report

TABLE OF TOTAL CITATIONS		
Citation	Description	# CITATIONS
CIC §790.03(h)(1)	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) CCR §2695.7(g)	The Company failed to respond to a Department of Insurance inquiry within 21 calendar days. The Company attempted to settle a claim by making a settlement offer that was unreasonable law.	3 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)

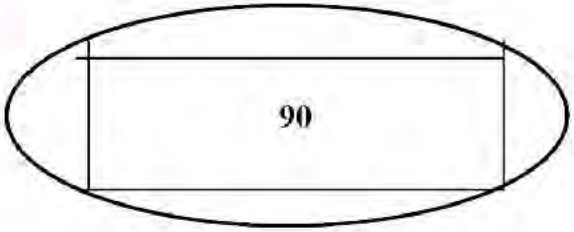
OF THE MARKET CONDUCT EXAMINATION

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



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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
CIC §10123.13(a)	42,137	139	42,276
CIC §734	0	45	45
CIC §790.02	0	47	47
CIC §10169(i)	0	27	27
CIC §10123.13(b)	5432	17	5449
CIC §10123.137(c)	0	14	14
CIC §10123.147(a)	0	5	5
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**

"Late Paid" claims & No EOP review notice → CIC §10123.13(a)

EOB - No IMR Notice → CIC §10169(i)

No Interest on "Late Pays" → CIC §10123.13(b)

No acknowledgment letter → CIC §10133.66(c)

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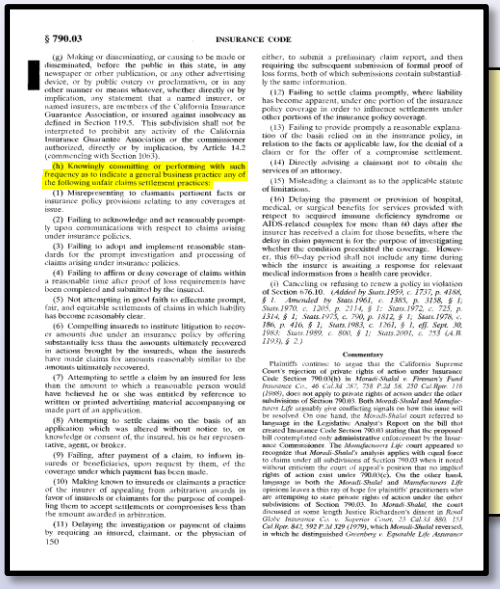
How Regulators Identify Unfair Claims Settlement Practices

- **Look for a practice -- either an intentional practice or one that occurs with sufficient frequency to infer a general business practice.**
- **Regulators apply the NAIC benchmark of 7% (in the absence of a separate state standard) in determining whether a business practice exists.**
- **Error rate greater than 7% creates a rebuttable presumption of a business practice.**

CALIFORNIA IS NO DIFFERENT



§ 790.03 INSURANCE CODE

(g) Making or disseminating, or causing to be made or disseminated, before the public in this state, in any newspaper or other publication, or any other advertising device, or by public outcry or proclamation, or in any other manner or means whatever, whether directly or by implication, any statement that a named insurer, or named insurers, are members of the California Insurance Guarantee Association, or insured against insolvency as defined in Section 119.5. This subdivision shall not be interpreted to prohibit any activity of the California Insurance Guarantee Association or the commissioner authorized, directly or by implication, by Article 14.2 (commencing with Section 1063).

(h) Knowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices:

(1) Misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

(3) Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.

(4) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured.

(5) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

(6) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds, when the insureds have made claims for amounts reasonably similar to the amounts ultimately recovered.

(7) Attempting to settle a claim by an insured for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or printed advertising material accompanying or made part of an application.

(8) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured, his or her representative, agent, or broker.

(9) Failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment has been made.

(10) Making known to insureds or claimants a practice of the insurer of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(11) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either, to submit a preliminary claim report, and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

(12) Failing to settle claims promptly, where liability has become apparent, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(13) Failing to provide promptly a reasonable explanation of the basis relied on in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.

(14) Directly advising a claimant not to obtain the services of an attorney.

(15) Misleading a claimant as to the applicable statute of limitations.

(16) Delaying the payment or provision of hospital, medical, or surgical benefits for services provided with respect to acquired immune deficiency syndrome or AIDS-related complex for more than 60 days after the insurer has received a claim for those benefits, where the delay in claim payment is for the purpose of investigating whether the condition preexisted the coverage. However, this 60-day period shall not include any time during which the insurer is awaiting a response for relevant medical information from a health care provider.

(i) Canceling or refusing to renew a policy in violation of Section 676.10. *(Added by Stats.1959, c. 1737, p. 4168, § 1. Amended by Stats.1961, c. 1383, p. 3158, § 1; Stats.1970, c. 1205, p. 2114, § 1; Stats.1972, c. 725, p. 1314, § 1; Stats.1975, c. 790, p. 1812, § 1; Stats.1978, c. 186, p. 416, § 1; Stats.1983, c. 1761, § 1, eff. Sept. 30, 1983; Stats.1989, c. 800, § 1; Stats.2001, c. 753 (A.B. 1293), § 2.)*

Commentary

Plaintiffs continue to argue that the California Supreme Court's rejection of private rights of action under Insurance Code Section 790.03(h) in *Moradi-Shalal v. Fireman's Fund Insurance Co.*, 46 *Cal.3d 287, 758 P.2d 58, 250 Cal.Rptr. 116 (1988)*, does not apply to private rights of action under the other subdivisions of Section 790.03. Both *Moradi-Shalal* and *Manufacturers Life* arguably give conflicting signals on how this issue will be resolved. On one hand, the *Moradi-Shalal* court referred to language in the Legislative Analyst's Report on the bill that created Insurance Code Section 790.03 stating that the proposed bill contemplated only administrative enforcement by the Insurance Commissioner. The *Manufacturers Life* court appeared to recognize that *Moradi-Shalal's* analysis applies with equal force to claims under all subdivisions of Section 790.03 when it noted without criticism the court of appeal's position that no implied rights of action exist under 790.03(c). On the other hand, language in both the *Moradi-Shalal* and *Manufacturers Life* opinions leaves a thin ray of hope for plaintiffs' practitioners who are attempting to state private rights of action under the other subdivisions of Section 790.03. In *Moradi-Shalal*, the court discussed at some length Justice Richardson's dissent in *Royal Globe Insurance Co. v. Superior Court, 23 Cal.3d 880, 153 Cal.Rptr. 842, 592 P.3d 329 (1979)*, which *Moradi-Shalal* reversed, in which he distinguished *Greenberg v. Equitable Life Assurance*

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<u>§790.03(h)</u>

Knowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices

CDI Is No Different than Other Regulators In Applying Tolerance Thresholds

- **Guided by NAIC handbook.**
- **CDI has applied specific tolerance thresholds in monitoring compliance with California law.**
  - PacifiCare Undertakings.
  - United MAWG Settlement.
  - MEGA settlement. California expressly adopted NAIC benchmarks for monitoring compliance.
- **Applying standard of substantial compliance or some other similar metric.**
  - Blue Shield – Substantial compliance.
  - Metropolitan – Industry standard.

Do Unfair Claims Settlement Practices Exist Here?

Nature of Alleged Violations	Evidence of an Intentional Practice?	Number of Alleged Violations	Relevant Population	Percentage of Error	Within Tolerance Thresholds?
Failing to timely acknowledge claims	**NO**	56,463	1,119,599*	5.04%	**YES**
Failing to pay claims timely.	**NO**	34,997	1,125,707	3.11%	**YES**
Failing to pay interest on late paid claims.	**NO**	5,195	34,997	14.84%	**NO**
Failure to pay claims accurately (Retro claims)	**NO**	3,700	1,125,707	0.33%	**YES**
Untimely requests for overpayment recovery.	**NO**	1,934	Insufficient evidence in the record to make an assessment		
Failing to timely respond to provider disputes.	**NO**	1,510	Insufficient evidence in the record to make an assessment		

*Total population less member claims

Conduct Arising Out of One Act or Omission

- **Requires different analysis.**
- **Here, the inclusion or omission of language in a form occurred one time.**
- **Categories implicated:**
  - EOPs
  - EOBs
  - Pre-ex exclusionary period in policy form.
- **The principle is consistent with §790.035.**

"The commissioner shall have the discretion to establish what constitutes an act. However, when the issuance, amendment, or servicing of a policy or endorsement is inadvertent, all of those acts shall be a single act for the purpose of this section." §790.035(a).

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

Relative Number of Claims

- **Comparison has to be fair.**
  - Focus on raw number of alleged violations is inappropriate.
  - CDI relied on limited sample populations in other examinations of health insurers.
  - CDI failed to evaluate whether the percentage of alleged violations is excessive compared with the analogous percentages in the other CDI examinations.
- **Form violations would have been substantially higher for other health insurers.**
  - By definition: 100% non-compliant.
  - The number of non-compliant forms (assuming CDI's interpretation is correct) is far higher for some large health insurers including one (Blue Cross) who was the subject of an examination and assessed a penalty of only $1 m.

Remedial Measures

- **CDI acknowledges that non-compliant conduct has been remediated.**
- **CDI did not need to bring this action to effect compliant behavior.**
  - PacifiCare voluntarily engaged in remedial measures with limited oversight and interest by CDI.
  - CDI had the opportunity but failed to provide input into nature of corrective actions.
- **Sound public policy dictates that remedial measures not be used against a licensee.**

Degree of Harm

- **Generally, the primary concerns are measurable monetary losses associated with an insurance policy and/or the denial of insurance benefits.**
- **Minimal harm at issue given CDI's extensive review of the claims at issue and as compared to other enforcement actions.**
- **Absence of egregious conduct or impact on vulnerable constituents.**

Harm to the Regulatory Process

- **Harm to the regulatory process involves extreme circumstances that undermine operation of the regulatory process.**
  - The blatant refusal of a licensee to cooperate.
  - Fraud or deceit in the licensee's dealings with the regulator.
- **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.**

No Harm to the Regulatory Process Here

- **PacifiCare cooperated from the outset.**
- **PacifiCare was candid about operational issues it was facing.**
- **PacifiCare went to great lengths to appease CDI and conform itself to the positions CDI was taking.**
  - Berkel letter.
  - Extensive remediation efforts.
- **Allegations of misrepresentations.**
  - Confusion about the issue of provider claim acknowledgement.
    - New law.
    - Confusion by CDI.
    - Confusion by the Company.
  - Company clarified the confusion in March 2008.

Impact on Amount of Penalty (If Any)

- **Discretion must be exercised consistent with historical penalties.**
- **Given the lack of notice and the relative harm here as compared to other enforcement actions, the penalty (if any) should be less than any of the significant ones.**
- **Dr. Kessler's conceptual approach is consistent with what regulators do.**

What Message Will CDI Be Sending the Industry?
THE WRONG ONE

- **The regulator is your adversary.**
- **Punishment is more important than compliance.**
- **CDI is unwilling to notify the industry about what is compliant behavior but will punish the industry for failing to meet its undisclosed expectations.**
- **Cooperation and openness are not valued.**
  - Don't share information voluntarily.
  - Don't self report.
  - Be cautious about engaging in corrective actions.
- **Don't be candid or self critical in your internal communications.**
- **Precedent has no meaning.**