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PACIFICARE LIFE AND HEALTH  
INSURANCE COMPANY

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  
  
**PACIFICARE'S PROPOSED  
FINDINGS OF FACT**  
  
Judge: Hon. Ruth S. Astle

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1 PacifiCare Life and Health Insurance Company (“PLHIC”) submits these Findings of  
2 Fact and Conclusions of Law in support of its Trial Brief.

3 **I. THE MERGER**

4 1. In July 2005, PacifiCare Health Systems Inc. (“PacifiCare”) (PLHIC’s parent  
5 corporation) and UnitedHealth Group Incorporated (“United”) publicly announced their plans for  
6 a \$8.2 billion merger, the third largest healthcare combination in history (the “Merger”).<sup>1</sup>

7 (*McFann Tr. 10593:20-22, Berkel Tr. 7346:20-7347:2*)

8 2. At the time of the Merger, in December 2005, PLHIC’s preferred provider  
9 organization (“PPO”) business in California -- which is regulated by the California Department  
10 of Insurance (“CDI” or the “Department”) -- had 119,648 members out of a total PacifiCare  
11 membership of 3,343,322, or 3.5%. (*Exh. 5590*)

12 3. The vast majority of PacifiCare’s California membership was in its health  
13 maintenance organization (“HMO”) business, managed by a separate licensee, PacifiCare of  
14 California (“PCC”), and regulated by the California Department of Managed Health Care  
15 (“DMHC”), not CDI. (*Berkel Tr. 7316:3-25, McMahon Tr. 15585:14-15, Campbell Tr.*  
16 *5859:24-5860:1*)

17 4. In connection with obtaining CDI’s approval for the Merger, PacifiCare and United  
18 executives attended a hearing in November 2005 called by then-Commissioner John Garamendi.  
19 (*Exh. 625*)

20 5. While CDI counsel has characterized the statements of PacifiCare and United  
21 executives at the November 2005 hearing as binding commitments or “promises,” the record of  
22 that hearing and the testimony presented in this hearing do not support that conclusion. (*Monk*  
23 *Tr. 9037:20-9038:7, 9039:11-20, 9045:20-9047:7, 9062:11-17; Exh. 625, p. 7139-7140*)

24 6. PacifiCare informed CDI in filings seeking approval of the Merger that “for  
25 reasons of confidentiality and antitrust regulations, due diligence procedures were often limited  
26

27 <sup>1</sup> These Findings will refer to PLHIC when referring specifically to the licensee and respondent in  
28 this proceeding, and “PacifiCare” or the “Company” when referring to the PacifiCare enterprise and  
operations as a whole, of which PLHIC was but a small percentage.

1 to non-sensitive information.” Therefore, any statements made by PacifiCare and United  
2 executives prior to the close of the Merger were preliminary at best. (*See PacifiCare’s Form A*  
3 *filing with CDI (CDI00043785), Request for Official Notice (“Reg. Off. Not.”), Tab 35*)

4 7. There were “constraints on United’s ability to get access to material information  
5 related to PacifiCare” because of United States Department of Justice (“DOJ”) restrictions on the  
6 parties prior to closing of the Merger. (*Berkel Tr. 7359:5-7360:4, Wichmann Tr. 15910:18-*  
7 *15912:9*)

8 8. Nancy Monk, PacifiCare’s Senior Vice-President for Regulatory and Government  
9 Affairs, testified that she attended the November 2005 hearing and that the executives who  
10 testified never “characterized [their statements regarding staffing] as promises,” and “w[ere] in  
11 no position to make” any promises given that the hearing “prior to the acquisition being  
12 approved, and the two companies did not have the ability to exchange” detailed information.  
13 (*Monk Tr. 9037:20-9038:7, 9039:11-20, 9045:20-9047:7, 9062:11-17; Exh. 625, p. 7139-7140*)

14 9. At the hearing, PacifiCare and United executives informed the Commissioner that  
15 “some positions in the corporation . . . will be eliminated as part of the cost savings,” but only  
16 identified with specificity potential layoffs in “public company positions, investment relations,  
17 things like that,” which they estimated to be “about 200 individuals.” (*Exh. 625, p. 7096*)

18 10. At the time of the hearing, Commissioner Garamendi required PLHIC to make  
19 written commitments in the form of formal “undertakings” (the “Undertakings”). (*Monk Tr.*  
20 *8742:24-8743:5; Exhs. 5191, 5282, 5283 and 5289*)

21 11. The Undertakings represented the complete terms of any commitments agreed to  
22 between PLHIC and the Commissioner and the Undertakings expressly represented that its terms  
23 constituted “the entire agreement and undertakings of the parties . . . and supersede all prior  
24 agreements and undertakings, both written and oral . . .” (*Exh. 5191, p. 9395, 20(h)*)

25 12. In connection with the Undertakings, PLHIC agreed to performance requirements  
26 designed to be “reflective of PLHIC’s historic performance.” (*Monk Tr. 8755:2-8756:4; Exh.*  
27 *5191*)

28

1           13. With respect to timeliness of claims payment, the Undertakings required PLHIC to  
2 process at least 92% of its claims within thirty (30) calendar days from receipt of the claims (a  
3 stricter standard than required by California law). (*Monk Tr. 8755:2-8756:12; Exh. 5191, p. 15*)

4           14. The “Department [does not] dispute that PLHIC has complied with the metrics in  
5 Undertaking 19 identified” for claims payment timeliness. (*Cignarale Tr. 22787:14-18, Monk*  
6 *Tr. 8767:9-12, 18067:6-10*)

7           15. The Undertakings included no commitments around staffing in California. (*Exh.*  
8 *5191*)

9           16. CDI expressly told PLHIC that it would not require an undertaking about staffing  
10 because “[t]hat’s not the way we conduct our oversight,” and that it was not CDI’s practice to  
11 approve or require staffing changes or decisions. (*Monk Tr. 8833:8 – 8834:18*)

12           17. On December 19, 2005, CDI approved the Merger in a letter to PLHIC in which it  
13 stated that “approval is hereby granted . . . based on the information, commitments, and  
14 documentation filed with the above-captioned matter, including specifically the Undertakings to  
15 the California Department of Insurance . . . .” (*Exh. 5282*)

16           18. The Merger closed on December 20, 2005. (*McFann Tr. 10593:23-24*)

17           **A. PacifiCare and United Integrate Their Operations.**

18           19. The combination of PacifiCare and United was the third largest merger of  
19 healthcare companies in history, and, by definition, presented numerous challenges and  
20 complexities. (*Berkel Tr. 7346:20-7347:2, 7462:15-7463:6, McNabb Tr. 19835:24-19836:25;*  
21 *Exh. 5617*)

22           20. At the time of the Merger, PacifiCare’s business was complex. Among other  
23 things, it included six different product types, including no less than 132 PPO plans, eight  
24 different legacy operating platforms and business in nine states and other territories. (*Exh.*  
25 *5590*)

26           21. The integration efforts included significant improvements in claims handling  
27 processes for PLHIC, including, but not limited to, standardized mail room operations, document  
28 imaging, routing and tracking, more robust quality controls and standardized processes around

1 eligibility that reduced the risk of error. (*McNabb Tr. 19826:23-19829:4 (re: mailroom)*),  
2 *20067:25-20068:9 (re: no obvious disruption to claims processing)*, *20628:8-20630:17 (re:*  
3 *quality of provider data)*, *McFann Tr. 12354:5-12356:5 (re: migrating call centers)*, *Vavra Tr.*  
4 *13897:9-13899:2 (re: mailroom)*, *Berkel Tr. 7818:1-15 (re: eligibility)*, *7443:15-7444:21 (re:*  
5 *improved examiner feedback and incentive program)*, *Labuhn Tr. 5570:7-23 (re: paper*  
6 *eligibility)*, *Vonderhaar Tr. 6853:2-24 (re: quality)*; *Exh. 5296, Exh. 5264, p. 2)*

7 22. Many of the improvements in mail routing and claims handling involved  
8 transitioning from a “manual process” “that [was] in people’s heads” to a more standardized,  
9 automated system resulting in a “much better process.” (*Vonderhaar Tr. 6324:13-6329:20,*  
10 *6794:8-6796:2 (re: manual mailroom processes)*, *6805:22-6806:4, Berkel Tr. 7454:5-23,*  
11 *McNabb Tr. 19829:25-19833:5 (re: Lason transition)*, *Vavra Tr. 13896:18-13899:2 (re:*  
12 *mailroom manual ops transition)*, *Lippincott Tr. 15227:7-15228:2 (re: EPDE transition))*

13 23. PacifiCare understood that when transitioning from a manual, non-standard process  
14 to an automated one that “there will be some disruption,” but it reasonably believed it “designed  
15 the best process it could” such that the various “process[es] today [are] much better than [they  
16 were] before [PacifiCare] started.” (*Vonderhaar Tr. 6324:13-6329:20, 6769:6-6771:6,*  
17 *Lippincott Tr. 15227:7-15228:2 (re: EPDE transition))*

18 24. PacifiCare and United applied substantial resources to their integration efforts.  
19 (*Wichmann Tr. 15911:7-15913:4; Exh. 5398; Greenberg Tr. 11985:18-24, 11986:19-24)*

20 25. Specific integration projects that have been discussed in this hearing, such as  
21 Lason, Accenture, and staffing changes in the Transactions or Claims department, among others,  
22 specifically included participation and decision making by legacy PacifiCare managers.  
23 (*McNabb Tr. 19829:5-17 (re: Lason)*, *Labuhn Tr. 5486:19-5487:14 (re: Accenture)*, *Watson Tr.*  
24 *17733:21-17736:9 (re: Accenture)*, *Norket Tr. 2287:13-2288:1 (claims department transition)*,  
25 *Vonderhaar Tr. 6782:2-24 (re: MedPlans)*)

26 26. The Operations Integration team led by Sue Berkel was staffed entirely with legacy  
27 PacifiCare employees. (*Berkel Tr. 7714:4-7718:21; Exh. 5264, p.1)*

28

1           **B.    The CTN Termination.**

2           27.    On December 22, 2005, two days after the Merger closed, Blue Shield of California  
3 terminated United’s access to Blue Shield’s CareTrust Network (“CTN”) (a network of  
4 providers) in California on six months’ notice despite having cooperated with United and the  
5 DOJ to allow United’s access to continue for one year after the Merger. (*Exh. 5344; McFann Tr.*  
6 *10612:21-10613:19, 12950:11-15*)

7           28.    United had relied on CTN since 2001 to provide medical care for up to one million  
8 California members. (*McFann Tr. 10590:16-10591:12; Exh. 5341*)

9           29.    The CTN termination created significant confusion and disruption in the healthcare  
10 provider community due in part to an unprecedented effort by United to re-contract with  
11 thousands of network doctors (including many within the PacifiCare network) in a short period  
12 of time or otherwise risk a significant loss of member access to medical care. (*McFann Tr.*  
13 *10597:1-13, 10756:20-24, 2100:19-2101:8, Berkel Tr. 7372:24-7374:5, 7425:5-12, 7376:18-*  
14 *7377:2, Monk Tr. 9138:8-13, McNabb Tr. 20403:4-13; Exh. 469*)

15           30.    At the time of the CTN termination, the difference or “gap” between the PacifiCare  
16 provider network and CTN’s network was approximately 8,000 providers. (*McFann Tr.*  
17 *2100:19-22, 2141:19-2142:16*)

18           31.    CDI contends that PLHIC overstated the importance of re-contracting these 8,000  
19 providers and failed to disclose that only half of the 8,000 providers had any claims spend in the  
20 year prior to the CTN termination.

21           a.    CDI’s contention is unfounded. On June 26, 2006, PLHIC’s Nancy Monk sent to  
22 DMHC and CDI’s Nettie Hoge a letter describing the CTN transition and disclosed  
23 that 4,000 of the 8,000 providers did not have claims spend in the prior year. (*Exh.*  
24 *5297; Monk Tr. 8840:20-25, 8926:18-8927:1, 9153:1-9158:15*)

25           b.    Irrespective of whether some of the providers had claims activity in the prior year,  
26 it was necessary for PacifiCare/United to re-contract the entire CTN network to  
27 ensure no disruption in service to those members who elected to seek medical care  
28 from one of those providers at some point in the future. (*McFann Tr. 10654:15-*

1 *10655:5, 10735:24-10736:9, Monk Tr. 9159:8-14, 9145:11-17, Berkel Tr.*  
2 *8058:20-8059:23)*

3 **C. Absence of Causation To Alleged Integration Mistakes.**

4 32. While CDI has questioned a number of decisions impacting the integration efforts,  
5 CDI has failed to cite any legal or regulatory standards that these alleged mistakes in the  
6 integration failed to meet. (*Boeving Tr. 19143:13-19145:14, Cignarale Tr. 23288:10-23289:11,*  
7 *23291:13-23293:19, 23294:5-23304:5, Stead Tr. 24867:11-24874:7; Exhs. 5593)*

8 33. Significantly, CDI’s integration expert Ronald Boeving did not “take an  
9 opportunity to familiarize [himself] with the nature of the [the] alleged violations” at issue in this  
10 proceeding, and admitted that he did not “link a mistake in the integration with” any specific  
11 violations of an Insurance Code provision or regulation alleged in this proceeding. (*Exh. 5593;*  
12 *Boeving Tr. 19143:7-19145:14)*

13 34. PLHIC’s regulatory expert Sue Stead testified that it is highly irregular for a  
14 regulator such as CDI to be “second-guessing, [and] critici[zing] business decisions that  
15 PacifiCare made” concerning integration issues “because regulators don’t get into those kinds of  
16 details,” and lack the requisite knowledge and expertise to do so. (*Stead Tr. 24332:25-*  
17 *24335:17)*

18 35. Deputy Commissioner Cignarale, head of both the consumer services and market  
19 conduct divisions for CDI, admitted he did not “know whether the Department has ever looked at  
20 the operations of other health insurance companies in connection with integration practices,” and  
21 that he had “no basis to compare this particular integration and what happened as compared to  
22 any of the other health insurers that have been the subject of a merger in California.” (*Cignarale*  
23 *Tr. 23748:12-16, 23750:20-23751:5)*

24 36. Deputy Commissioner Cignarale also did not independently examine the record in  
25 this proceeding and was asked by CDI counsel to accept without verification that the integration  
26 affected five categories (COCCs, late pays, incorrect claims payments, member claims  
27 acknowledgment and overpayment recoveries) of alleged violations in this proceeding.  
28 (*Cignarale Tr. 23261:14-21, 23294:5-23304:5, 23266:7-23269:23)*

1           37. The record does not otherwise support a finding that there was any link between the  
2 bulk of the alleged violations and the integration issues identified by CDI. (*Exhs. 5593, 5370;*  
3 *Stead Tr. 24867:11-24874:7, Berkel Tr. 11245:23-11253:19, Lippincott Tr. 17310:6-9, McNabb*  
4 *Tr. 21598:6-8, Boeving Tr. 19143:3-19145:4, Cignarale Tr. 23304:15-19, Zaretsky Tr. 18891:3-*  
5 *7)*

6           38. PLHIC’s post-Merger performance metrics also do not support any finding that the  
7 integration caused any materially negative impact on PLHIC’s claims-handling operations. In  
8 addition to exceeding the claims payment timeliness standard in Undertaking 19, PLHIC’s  
9 performance with respect to Underpayment Claim Payment Accuracy (“UCPA”) and Dollar  
10 Accuracy Rate (“DAR”) was also consistent with industry standards. (*Exhs. 609, 5226, pp. 5-6,*  
11 *5252, p. 9, 5262, 5615, pp. 4-5; Berkel Tr. 7664:12-21, 7666:10-20, Goossens Tr. 7272:7-*  
12 *7273:11, 7275:17-20, McNabb Tr. 19799:25-19800:25, 21568:24-21569:5, 21572:6-25,*  
13 *22357:20-22358:7)*

14                   1. Ronald Boeving’s Testimony

15           39. Mr. Boeving’s admissions support several findings that limit the weight of his  
16 overall testimony and opinions in this proceeding.

17           40. Mr. Boeving’s opinions with regard to the negative impact of certain alleged  
18 integration mistakes on PLHIC’s claims handling performance were wholly conclusory as he  
19 conceded that “I don’t believe I have quantified [the] impact,” if any, from those integration  
20 activities. (*Boeving Tr. 19143:13-19145:14, 19200:13-19201:10, 19403:3-14)*

21           41. Mr. Boeving admitted he “didn’t look at all of the evidence related to the  
22 integration of the two companies” (*Boeving Tr. 19138:17-20*) and admitted he has “no idea  
23 whether there’s evidence on any of these subject matters outside of what [he] reviewed.”  
24 (*Boeving Tr. 19142:24-19143:06*)

25           42. Mr. Boeving admitted that he had not seen a list of the PLHIC project summaries  
26 relating to the integration, and when shown such a list (*Exh. 5591*), he testified that he did not  
27 “have the ability to opine on [the integration projects] or assess them based on whether they  
28 [were] done well or not.” (*Boeving Tr. 19116:19-25*)

1           43. Mr. Boeving admitted to never having worked for a health insurer nor has he ever  
2 been involved in the merger of two health insurers. (*Boeving Tr. 19108:4-20*)

3           44. Mr. Boeving admitted that he did not identify or quantify the impact, if any, on  
4 PLHIC’s claims handling caused by any of the alleged integration mistakes he discussed in his  
5 Pre-Filed Testimony:

6           a. Mr. Boeving admitted that he “nowhere identified” the impact caused to the claims  
7 operation “by outsourcing of mailroom functions and by issues surrounding REVA  
8 and DocDNA.” (*Boeving Tr. 19200:13-20*)

9           b. Mr. Boeving conceded that he “nowhere quantified” “the EPDE implementation,  
10 DocDNA delays, UFE transition, [and] Lason transition” on “the claims payment  
11 performance.” (*Boeving Tr. 19200:21-19201:10*)

12           c. Mr. Boeing opined that the EPDE implementation “resulted in a large number of  
13 provider checks [being sent to the wrong address]” (*Boeving Tr. 19407:03-09*), but  
14 he conceded that he does not know the number nor whether “the volume of  
15 returned checks actually *decreased* after EPDE” went into effect. (*Boeving Tr.*  
16 *19407:7-14, italics added*)

17           d. Although Mr. Boeving claimed in his written testimony that “[m]any problems  
18 with [the RIMS reconciliation] process were discovered only after external  
19 customers complained to the company,” he acknowledged that he did not have any  
20 documentation to back up this claim. (*Boeving Tr. 19417:02-13*)

21           e. Mr. Boeving agreed that he “really [didn’t] know what was done or not done in  
22 connection with the whole transition” and that “nowhere in [his] written testimony”  
23 did he conclude that “insufficient diligence was conducted.” (*Boeving Tr.*  
24 *19172:17-20, 19191:2-19192:15*)

25           45. Although Mr. Boeving testified that he “specializes in Information Technology (IT)  
26 management and planning for IT support of critical initiatives for healthcare companies,” it  
27 appears to the Court that Mr. Boeving attempted to opine on issues outside of his claimed  
28 expertise.

1           46. Mr. Boeving admitted to never having led an entire integration of two companies,  
2 rather, he was only responsible for the IT aspects. (*Boeving Tr. 19108:15-20*)

3           47. In his Pre-Filed Testimony, however, Mr. Boeving purported to offer criticisms  
4 outside of his claimed areas of expertise -- "IT management and planning" -- such as staffing  
5 reductions and the outsourcing of eligibility and mail room functions, even though he admitted  
6 he has no "special knowledge, skill, experience [and] training" in "staff reductions outside of the  
7 IT area" (*Boeving Tr. 19131:5-19132:1*) or in evaluating the actions of "specific officers outside  
8 of the IT area" (*Boeving Tr. 19134:13-22*)

9           48. In his Pre-Filed Written testimony, Mr. Boeving claimed to have led the IT  
10 integration for "5 relatively large acquisitions (above \$150 million)." (*Exh. 1093, p. 1:23-25*)  
11 Mr. Boeving identified these as First Health, CCN, Health Net Employer Services, Affordable  
12 Healthcare and CAC.

13           49. PLHIC established, however, that Mr. Boeving was only involved in the IT  
14 integration of two such "acquisitions above \$150 million."

15           a. First Health reported in its 10-K for December 2003 that it acquired Health Net  
16 Employer Services for \$79 million. (*Boeving Tr. 19094:10-12, 19095:17-*  
17 *19096:22; Exh. 5588*)

18           b. Healthcare Compare Corp. reported in its 10-K for 1998 that the purchase price for  
19 the Affordable Healthcare transaction was \$6 million. (*Exh. 5609*)

20           c. First Health reported in its 10-K for December 2002 that the purchase price for  
21 CAC was only \$18 million, well below the \$150 million that Mr. Boeving had  
22 claimed. (*Exh. 5595*)

23           **D. The Focus on Synergies Was Reasonable.**

24           50. Synergies represent the financial and non-financial benefits that are created when  
25 two or more organizations are combined that are greater than the sum of their separate  
26 operations. (*Exh. 5615*)

27           51. PacifiCare and United's focus on realizing synergies from the Merger was  
28 reasonable. (*McNabb Tr. 19770:8-25; Exh. 5615, p. 2*)

1           52. Health insurers have a vested interest and incentive to contain rising health care  
2 costs and mergers represent an opportunity to reduce costs associated with combining operations.  
3 *(Berkel Tr. 7360:5-7361:4, Monk Tr. 8922:8-19, Watson Tr. 17747:3-9, Ho Tr. 15423:17-*  
4 *15424:5)*

5           53. PacifiCare disclosed to CDI its pre-Merger synergy estimates as part of its  
6 applications for approval of the Merger. *(PacifiCare’s Form A submission, filed with CDI*  
7 *pursuant to Section 1215.2(d), “Statement Regarding the Acquisition of Control of a*  
8 *Commercially Domiciled Insurer,” July 8, 2005, Reg. Off. Not. Tab 35)*

9           54. In fact, the Commissioner and his staff requested “specific recognition that synergy  
10 savings would occur and be captured as part the of the undertakings,” resulting in Undertaking  
11 14, which required “synergy savings that have been realized from the merger, . . . in part [to be]  
12 passed on to . . . consumers” in the form of “mitigating premium increases.” *(Monk Tr. 8919:1-*  
13 *8923:15; Exh. 5191)*

14           55. PacifiCare/United’s pre-Merger projected synergies were reasonable and well  
15 within the ranges reported by other healthcare mergers. *(Exh. 5615, p. 2; McNabb Tr. 19770:8-*  
16 *21; see also Exh. 457, p. 9242)*

17           56. Though CDI describes the focus on synergies as an effort to please “Wall Street,”  
18 the Company’s public statements about estimated synergy savings were conservative and did not  
19 impose internal pressures to achieve those expectations. *(Exh. 457, p. 9242; Wichmann Tr.*  
20 *18404:8-17; Exh. 625, p. 7096)*

21           57. The vast majority of the synergies realized in the first two years following the  
22 Merger derived from lines of business not subject to CDI regulation, such as the senior and  
23 pharmacy benefit management lines of business, and network access savings (approximately  
24 \$560 million), and were unrelated to layoffs. *(McNabb Tr. 19774:1-8; Exh. 457, p. 9255;*  
25 *Berkel Tr. 11243:17-22)*

26           58. CDI did not present any evidence tying the realization of synergy savings to any  
27 negative impact on PLHIC’s operations.

28

1           59. The Company also realized significant synergy savings associated with in-sourcing  
2 employees previously laid off by PacifiCare, including hiring approximately 300 IT employees.  
3 *(Berkel Tr. 11244:9-11244:22, McNabb Tr. 19773:2-20; Exh. 457, p. 9261)*

4           60. In connection with the Merger, the PacifiCare hired almost as many new employees  
5 as it laid off *(Berkel Tr. 7361:10-21, 11244:9-11244:22)* and United made the Cypress campus a  
6 technology center. *(Barbati Tr. 4128:4-21)*

7           **E. Specific Integration-Related Issues Not Relevant To These Proceedings.**

8           CDI failed to establish any causal link or nexus between the specific integration-related  
9 issues alleged in this proceeding and any of the charged violations, rendering all evidence  
10 related to these alleged integration mistakes irrelevant and immaterial to this proceeding.

11           Significantly, CDI’s integration expert Ronald Boeving did not “take an opportunity to  
12 familiarize [himself] with the nature of the [the] alleged violations” at issue in this proceeding,  
13 and admitted that he did not “link a mistake in the integration with” any specific violations of an  
14 Insurance Code provision or regulation alleged in this proceeding. *(See, e.g., Boeving Tr.*  
15 *19143:13-19145:14).*

16           Moreover, Deputy Commissioner Cignarale admitted he did not “know whether the  
17 Department has ever looked at the operations of other health insurance companies in connection  
18 with integration practices,” and that he had “no basis to compare this particular integration and  
19 what happened as compared to any of the other health insurers that have been the subject of a  
20 merger in California.” *(Cignarale Tr. 23748:12-16, 23750:20-23751:5)* Mr. Cignarale also  
21 admitted that he did not independently examine the record in this proceeding and was asked by  
22 CDI counsel to accept without verification that the integration affected five categories (COCCs,  
23 late pays, incorrect claims payments, member claims acknowledgment and overpayment  
24 recoveries) of alleged violations in this proceeding. *(Cignarale Tr. 23261:14-21, 23294:5-*  
25 *23304:5, 23266:7-23269:23)*

26           To the extent the Court is inclined to examine these integration issues in greater detail,  
27 PLHIC submits the following findings.  
28

1                   1. Integration Management

2                   61. PLHIC’s integration expert, Rick McNabb, provided the Court with extensive  
3 testimony concerning the combined companies’ application of a classic model of program  
4 management to manage the PacifiCare/United integration, including participation from both the  
5 United and legacy PacifiCare sides. (*Labuhn Tr. 5565:11-5567:14, McNabb Tr. 19739:9-  
6 19749:16, Berkel Tr. 7366:21-7367:10; Exh. 5615*)

7                   62. Mr. McNabb has over 25 years of experience advising health care companies and  
8 insurers with respect to integrations issues, and has either led or been actively involved in some  
9 of the largest healthcare integrations and IT transformations in the United States. Mr. McNabb  
10 has been involved in implementing new claims platforms, web portals, eligibility systems,  
11 medical management, membership and financial reporting systems, call centers and insurance  
12 products for numerous health plans throughout the United States. (*Exh. 5615, p. 1, 5616*)

13                   63. Mr. McNabb explained that based on his extensive experience with health care  
14 integrations, he observed that PacifiCare/United followed an industry standard structure for  
15 decision making and execution of the integration. In this case, the structure was comprised of an  
16 Advisory Council at the top level, with various operational and business groups reporting up to  
17 them, and interaction between these various groups managed by a project management team.  
18 (*McNabb Tr. 19741:14-19749:16, 19761:10-21; Exhs. 427, 5600*)

19                   64. Each of the integration and business teams that had day-to-day responsibility for  
20 the integration and running the business had representation from both legacy PacifiCare and  
21 United management. (*Exhs. 427, 5600, 5615, p. 3; Berkel Tr. 7799:15-7800:10, Vonderhaar Tr.  
22 5997:3-18, 6004:3-6005:23, 6766:12-24*)

23                   65. PacifiCare presented credible evidence that many of the problems highlighted by  
24 CDI involved routine operational issues and challenges encountered as well by other health  
25 insurers and large organizations (*e.g.*, computer programs that do not work flawlessly, human  
26 errors, etc.). (*Berkel Tr. 7476:10-19 (human error affects cutting checks), 7491:22-25 (provider  
27 terminations pre-dated merger), 7492:20-25 (problems with correct fee schedules occurred  
28 outside of integration), 7648:9-7649:17 (human error affects interest calculation), 8532:22-*

1 8533:3 (siloiing a problem at PacifiCare pre-merger), 9965:4-6 (retro contract loading),  
2 Lippincott Tr. 17306:18-17308:6 (demographic data challenging even outside of an integration),  
3 McFann Tr. 10683:9-13 (demographic data), 10684:4-8 (demographic data), McNabb Tr.  
4 19812:9-19813:6 (demographic data), 19830:15-19832:2 (non-keyable docs), 19834:5-19835:5  
5 (undocumented business rules))

## 6 2. Staffing

7 66. Based on the evidence in the record, the Court finds that layoffs did not materially  
8 impact the issues involved in this proceeding. (See, e.g., Exh. 5615, p. 2; Exh. 457 p. 9255;  
9 Vonderhaar Tr. 6173:14-20, Sing Tr. 2500:24-2501:13, Berkel Tr. 8478:7-12, Monk Tr.  
10 9016:12-9017:9)

11 67. The vast majority of the layoffs in 2006 were for employees in PCC's HMO  
12 business, for which PCC sought and obtained DMHC approval. (Monk Tr. 12360:23-12361:04,  
13 12362:1-11, 12364:16-20)

14 a. As to these layoffs, Ms. Monk testified that PCC informed DMHC that the greater-  
15 than-anticipated layoffs in 2006, and shifting of those responsibilities to other  
16 facilities in San Antonio, Texas, and Letterkenny, Ireland, were an attempt to  
17 stabilize PCC's service levels and workforce, which saw increased involuntary  
18 departures and disruption following the Merger, a fact specifically identified in  
19 contemporaneous materials used by PCC to brief DMHC. (Monk Tr. 8826:18-  
20 8829:3, 12365:21-12366:2; Exh. 5546, p. 14)

21 68. Although CDI alleged that staffing decisions were based solely on United's staffing  
22 ratios, PLHIC demonstrated that staffing decisions have "always been related to workload."  
23 (Monk Tr. 18061:6-18)

24 69. Former PLHIC employee, Ruth Watson, confirmed that a lot of work was put into  
25 "trying to do the right thing" with respect to these layoffs and the Company employed an  
26 "unbiased" process to identify who would be laid off based on objective factors, such as "time  
27 and service" with the company, "performance on the last performance review," "the key skills  
28

1 [the] person needs to be effective,” and an assessment of how “that person perform[s] against  
2 these key attributes.” (*Watson Tr. 17658:13-25, 17734:10-17736:16, 17810:6-9, 17742:7-9*)

3 70. Many of the staffing changes and reductions criticized by CDI had already been  
4 planned by PLHIC and/or were underway before the Merger had even been announced. With  
5 respect to mailroom operations, PacifiCare legacy employee Jonathon Murray, who responsible  
6 for the transition of mailroom operations, was “going down the path of outsourcing mailroom  
7 operations” “prior to the acquisition even being announced,” and with respect to eligibility data  
8 entry, the legacy head of that department, Ruth Watson, a CDI-offered witness, testified that “I  
9 was looking at it before United came.” (*Watson Tr. 17739:1-4, Murray Tr. 3165:13-3166:13, see  
10 also Vavra Tr. 13884:22-13885:2, 13886:3-13886:25*)

11 71. The Director of PacifiCare’s PPO Customer Service centers confirmed that the  
12 March 2006 layoffs in Cypress had minimal effect on his team because “we had actually been in  
13 the process of moving frontline service work from California to Texas for at least two years prior  
14 to that,” and West Corporation in Huntsville, Alabama “would have been supporting member  
15 and provider calls” “back in 2002.” (*Sing Tr. 2500:24-2501:13, 3340:2-3341:14, 3344:23-  
16 3345:25*)

17 72. By 2005, well before the Merger, PacifiCare was already migrating work  
18 performed by California staff to San Antonio and Letterkenny. (*Vonderhaar Tr. 6173:14-20,  
19 6175:22-6176:4, Monk Tr. 12382:15-18, Norket Tr. 2293:4-21*)

20 73. By the time of the Merger, PLHIC had transferred most of its new day and re-work  
21 PPO claims processing functions to its San Antonio facility and its vendor, MedPlans (formerly  
22 First Source). (*Vonderhaar Tr. 6163:13-21, 6956:5-12, 6173:14-20, 6175:9-6177:7, 6775:8-  
23 6776:4*)

24 74. As a result, the number of employees handling PLHIC claims stayed roughly the  
25 same after the Merger because the company was able to add claims examiners in San Antonio,  
26 Texas and at MedPlans to perform the work of the twenty-two (22) departing PLHIC PPO  
27 California claims examiners, who were also given an opportunity to move to San Antonio.  
28

1 *(Berkel Tr. 7361:10-21, 8478:9-12, Vonderhaar Tr. 6163:12-21, 6956:5-12, Norket Tr. 2330:7-*  
2 *2331:19)*

3 75. Although CDI characterizes PacifiCare’s outsourcing activities as layoffs, those  
4 changes were not outright staffing reductions, but rather the transfer of operational activities to  
5 companies whose employees were trained and specialized in those functions. *(Watson Tr.*  
6 *17733:24-17734:9, Labuhn Tr. 5492:24-5493:25, McNabb Tr. 19957:23-19958:3; Exh. 5615, p.*  
7 *2)*

8 76. The outsourcing of the mailroom and data entry functions for eligibility is a  
9 standard practice within the industry. *(McNabb Tr. 19827:8-20, 19833:6-21, 19771:16-*  
10 *19772:15, 20072:2-4, Boeving Tr. 19156:7-15)*

### 11 3. RIMS Migration

12 77. From PLHIC’s perspective, one of the principal goals of the Merger was to gain  
13 access to United’s superior PPO product and related technology. *(Monk Tr. 8784:6-20, Harvey*  
14 *Tr. 11794:7-22; Exh. 426)*

15 78. Pre-Merger, PLHIC had already determined that RIMS was not a strategic platform  
16 for continued growth of its PPO business, especially in view of the fact that the “functionality of  
17 the United claims platforms [was] very broad and reache[d] out to both the brokers, the employer  
18 groups and the members in a way that RIMS never did.” *(Berkel Tr. 7326:12-22, Vonderhaar*  
19 *Tr. 6051:3-19, McNabb Tr. 19796:2-19797:1)*

20 79. Prior to and immediately after the Merger, Company executives had preliminary  
21 plans to build RIMS’ claims processing functionality onto United’s superior UNET platform (the  
22 claims engine United uses to process its PPO claims). *(Greenberg Tr. 11956:11-21, Vonderhaar*  
23 *Tr. 6051:3-13, McNabb Tr. 21461:25-21462:3; Exh. 653)*

24 80. By necessity, those plans were preliminary in nature because of “constraints on  
25 United’s ability to get access to material information related to PacifiCare” during the “quiet  
26 period [when] information is not exchanged” by order of the Department of Justice. *(Berkel Tr.*  
27 *7359:5-7360:4; Exh. 5342 (DOJ Judgment))*

1           81. Following the Merger, a combined PacifiCare/United team was assigned to plan  
2 and implement the platform migration strategy. (*Berkel Tr. 7957:15-23, Greenberg Tr.*  
3 *11956:22-11958:4, 11959:10-18, 11966:11-22; Exhs. 800, 647, 652)*

4           82. By May of 2006, the team began to assess alternatives to the initial strategy of  
5 migrating the RIMS platform and concluded by August 2006 that the platform migration strategy  
6 should be modified to one of membership migration because United would be “offering a very  
7 similar product with superior technology on United platform.” (*Greenberg Tr. . 11973:18-*  
8 *11980:7, 11966:23-11968:20, 11963:11-19, 11965:20-11966:10; Exhs. 652, 653, 5394, 5395,*  
9 *5396, 5397, 5399)*

10           83. The team also believed membership migration was superior because of a “concern”  
11 that “the platform migration might actually disrupt the members’ experience if it was  
12 implemented” because it involved “[b]uilding . . . new capabilities on United platform that didn’t  
13 exist.” (*Greenberg Tr. 11975:19-11976:20, 11970:14-18, Monk Tr. 8783:13-19)*

14           84. The Advisory Council, the apex committee made up of senior PacifiCare and  
15 United executives, approved the change from a platform migration to membership migration  
16 strategy in September 2006. (*Greenberg Tr. 11979:22-11981:12; Exh. 5397, p. 20)*

17           85. Under the membership migration strategy, United offered PacifiCare employer  
18 groups and potential customers the option of transferring PPO coverage to United’s UNET  
19 product on a no loss basis, with no restrictions for pre-existing conditions or premium, in what  
20 was called a “voluntary migration” strategy. (*Greenberg Tr. 11972: 9-21, 11982:17-25,*  
21 *12159:13-17, Berkel Tr. 7840:20-7841:21)*

22           86. Many PLHIC PPO members moved to the UNET platform product as a result of  
23 this offering, and those who remained on RIMS continued to be serviced by that platform.  
24 (*Greenberg Tr. 12201:7-19, Berkel Tr. 7841:15-21, McNabb Tr. 19803:25-19804:8; Exh. 284)*

25           87. During the hearing, CDI counsel repeatedly suggested that post-Merger, PacifiCare  
26 and United had actually executed a strategy to migrate RIMS to United’s systems, but PLHIC  
27 and United witnesses testified that this activity never went beyond the strategy phase, and  
28 explained that no capital budget had ever been requested, approved or funded for such a project.

1 *(Berkel Tr. 8324:22-8325:5, 8326:17-25, 8368:6-21, 8393:22-8394:23, 8396:13-8397:11,*  
2 *Greenberg Tr. 11961:12-11963:10; Exh. 5394, p. 6, 36)*

3 88. PLHIC's expert Mr. McNabb testified that he reviewed the materials and testimony  
4 concerning the platform migration planning and execution and found that it was reasonably  
5 managed given the changing business and strategic needs that faced the companies post-Merger.  
6 *(McNabb Tr. 20181:18-20182:6, 19794:8-19795:2)*

7 89. PLHIC witnesses and Mr. McNabb also testified that the decisions to change the  
8 platform migration strategy did not negatively impact PLHIC operations *(McNabb Tr. 19799:25-*  
9 *19801:10, 21594:19-24, 21596:5-15, Berkel Tr. 10381:11-15, Greenberg Tr. 11982:17-25; see*  
10 *also McNabb Tr. 19810:11-19811:5), did not affect the maintenance and operation of RIMS*  
11 *(McNabb Tr. 19803:25-19804:15, 19807:1-22; see also Berkel Tr. 8422:12-15, Way Tr.*  
12 *14201:23-14203:2, 14216:15-14217:8), and did not lead to any of the alleged violations cited in*  
13 *this hearing; nor does CDI link any issue concerning RIMS to any specific alleged violation.*  
14 *(Berkel Tr. 10381:11-15)*

15 4. RIMS Maintenance

16 90. CDI has alleged that PLHIC did not adequately maintain the RIMS claims  
17 platform, and that this inadequate maintenance led to violations of law. *(CDI Opening Merits*  
18 *Brief, p. 39:7-25)*

19 91. Extensive testimony by PLHIC witnesses and its expert, Mr. McNabb, and  
20 numerous exhibits introduced at trial demonstrate that PLHIC adequately maintained and funded  
21 the RIMS claims platform prior to and after the Merger. *(Berkel Tr. 7856:11-7858:1, 8126:2-13,*  
22 *8286:13-8287:6, 8290:8-14, 11336:11-11338:19, Vonderhaar Tr. 6806:16-6807:4, Way Tr.*  
23 *14187:19-14189:20, 14195:9-12, McNabb Tr. 19803:25-19804:15, 21482:13-21483:12; Exhs.*  
24 *5264, p.8, 5618)*

25 92. During the relevant period, the expenditure on the RIMS platform (both  
26 maintenance and capital improvements) remained constant:  
27  
28

(in millions)	2005	2006	2007	2008
Costs (non-capitalizable)	\$3.7	\$3.1	\$2.6	\$2.7
Development capitalized	\$2.8	\$1.4	\$3.0	\$2.6
Total	\$6.5	\$4.5	\$5.6	\$5.3

*(Berkel Tr. 7856:11-7858:1, 8126:2-13, 8286:13-8287:6, 8290:8-14, 11336:11-11338:19, Vonderhaar Tr. 6806:16-6807:4, McNabb Tr. 19803:25-19804:15, 21482:13-21483:12; Exhs. 5264, p. 8, 5618)*

93. During this 2005-2008 period, PLHIC upgraded RIMS on at least two occasions.

*(Berkel Tr. 7325:22-7326:7, McNabb Tr. 21483:3-18, Way Tr. 14206:5-14207:9, 14209:12-18)*

94. PLHIC executives made a reasonable decision not to further upgrade the RIMS software because there were no significant advantages or disadvantages in doing so. *(Way Tr. 14206:5-14209:1, 14210:3-17, McNabb Tr. 19808:1-19809:8, Berkel Tr. 8419:7-8420:1; Exhs. 5481, 5482)*

95. PLHIC's decision not to upgrade the RIMS systems was also reasonable because (a) "RIMS still was working well on the version [it was] on," and (b) any upgrade would have entailed significant risk and expense with no discernable benefit. *(Way Tr. 14206:5-14209:1, 14210:3-17, McNabb Tr. 19808:1-19809:8, Berkel Tr. 8419:7-8420:1; Exhs. 5481, 5482)*

96. Importantly, the Company ensured access to a long term maintenance contract through 2011 for the servicing of the RIMS platform by Trizetto and other vendors. *(Berkel Tr. 8422:12-15, 8431:15-8432:5, Way Tr. 14202:18-14202:10, 14213:7-9; Exh. 5465)*

97. CDI did not present any compelling or credible evidence that PLHIC's decision not to upgrade to higher versions of the software resulted in any operational deficiencies, or led to any of the specific violations alleged in this proceeding. *(Way Tr. 14210:3-17, Berkel Tr. 7436:19-7437:25, Greenberg Tr. 12144:24-12145:3; Exh. 5252)*

1           98. To the contrary, PLHIC presented documents and testimony of personnel  
2 responsible for maintaining RIMS that showed the RIMS platform was operational and available  
3 but for a few unrelated and very short outages that had no impact on claims processing. (*Way Tr.*  
4 *14223:6-17, 18268:12-22, 18269:18-25, McNabb Tr. 19801:5-19803:14, 21602:1-17; Exhs.*  
5 *5466, 1056*)

6           99. The one outage lasting more than a day resulted from “[a] thunderstorm [that] took  
7 out [a] data center on a late Saturday night.” There is no credible evidence in the record that the  
8 outage lasted any longer due to PLHIC’s decision not to upgrade the RIMS system. (*Way Tr.*  
9 *14221:9-14222:15, 14427:20-14428:14, Berkel Tr. 11220:7-23*)

10           100. CDI asserts that PLHIC should have upgraded RIMS Version 3.30 because that  
11 software had a “full relational database” and would have avoided any claim issues with provider  
12 data. (*Boeving Tr. 19275:22-19277:6*)

13           101. However, PLHIC demonstrated that Version 3.30 “did not” “have a relational  
14 database.” (*CDI Opening Merits Brief, p. 37:8-17; Boeving Tr. 19284:1-19287:10, McNabb Tr.*  
15 *19810:11-19811:5, 19816:4-12, 19821:2-19; Exh. 5615*)

16           102. Even if the new version did have a “relational database,” CDI could not identify  
17 any material difference in the structure of the provider demographic data tables with and without  
18 the relational database, such that utilizing a relational database would not have eliminated the  
19 challenges associated with maintaining provider data. (*McNabb, Tr. 19817:79-19819:18,*  
20 *Boeving Tr. 19360:4-8, 19360:12-18, 19361:16-21, 19363:1-3, 19363:25-19364:13, 19365:11-*  
21 *15, 19366:2-7, 19367:2-14, 19368:2-10, 19374:15-18, 19367:1-4; Exhs. 5603, 5607*)

22           103. The only difference Mr. Boeving identified between the RIMS version PLHIC was  
23 using and Versions 3.30 was the later version apparently possessed a National Physician  
24 Indicator (“NPI”) data field. (*Boeving Tr. 19372:9-15*). However, PacifiCare had already  
25 instituted NPI functionality into the RIMS system by February 2007, well before Trizetto had  
26 even added that functionality to RIMS. (*Exhs. 5069, 5603*)

27           104. CDI has criticized PLHIC’s “Keep the Lights On” (“KTLO”) approach to funding  
28 as “doing just the minimum,” but that term is used within the industry to mean that non-strategic

1 platforms or technology are to be supported to the extent necessary to meet business and  
2 regulatory requirements. (*McNabb Tr. 19803:15-24, 19935:16-22, Berkel Tr. 7849:5-7851:16,*  
3 *7854:11-7855:20, 8132:7-23, Labuhn Tr. 5419:18-25, Vonderhaar Tr. 6070:15-21, 6074:14-*  
4 *6075:1*)

5 105. The KTLO Committee managed a funding pool for capital expenditures that was in  
6 addition to operational budgeting sources, and acted as a “catch-all budget” to fund projects that  
7 were not otherwise being funded by other PacifiCare or United “funding pools.” (*Berkel Tr.*  
8 *8132:19-23*)

9 106. While CDI has presented internal documents authored by Sue Berkel in which she  
10 expressed concern about RIMS and IT budgeting, Ms. Berkel explained that at the time she  
11 prepared those materials (*e.g., Exhs. 342, 460*), she “[did not] have visibility to the spend for  
12 PacifiCare assets and other funding pools.” She explained that there were in fact, many other  
13 “funding pools” used to support PLHIC, such as Regulatory, Human Resources, IT, Finance,  
14 Health Services (medical management), membership growth, and Operations & Maintenance  
15 (RIMS maintenance). (*Berkel Tr. 8124:21-8129:8*)

16 107. In fact, Ms. Berkel confirmed that “at no time” “was IT capital constrained during  
17 the integration and migration period,” and she “had all the IT capital money [she] needed.”  
18 (*Berkel Tr. 8126:2-13, 8128:4-8129:24, 8286:13-8287:6, 8290:8-14, Way Tr. 14216:15-*  
19 *14217:8; Exhs. 342, 460*).

20 108. CDI failed to link any issue concerning the RIMS claims system to any alleged  
21 violation in this proceeding.

## 22 5. Lason/DocDNA

23 109. PLHIC’s pre-Merger document routing system “was a very manual process”  
24 without “any system to track the volumes that were coming in or going out of the mailroom,”  
25 and “very little ability to track what happened to mail once it was delivered out to various  
26 departments.” (*Murray Tr. 13673:16-24, Vavra Tr. 13883:12-13884:7, Vonderhaar Tr. 6879:7-*  
27 *15, Berkel Tr. 8513:25-8514:6, 7450:2-13*)

1           110. The pre-Merger system was complex; mail sorters were required to initially process  
2 86 different correspondence “document types” into 69 “decision groups” that they further  
3 manually divided and physically routed to 163 “destinations in eight states.” (*Murray Tr.*  
4 *14386:3-14387:15; Exhs. 5469, 5468*)

5           111. PLHIC’s legacy mail intake and routing system had little to no “documentation that  
6 was provided to the mailroom to assist them in understanding . . . correspondence types” or to  
7 assist them in “figuring out where to send [a] piece of mail.” (*Murray Tr. 13682:6-13683:13,*  
8 *14387:9-14389:8, Berkel Tr. 7453:14-7454:6*)

9           112. PLHIC’s paper, manual routing system also made it virtually impossible to conduct  
10 effective reconciliation of received and routed mail, and required personnel to manually search  
11 file cabinets for documents, as opposed to using data reporting systems. (*Vavra Tr. 13883:6-*  
12 *13884:16, Berkel Tr. 7452:6-11*)

13           113. PacifiCare and United agreed that pre-Merger PLHIC processes created  
14 unacceptable business risk and would greatly benefit from automation and outsourcing.  
15 (*Vonderhaar Tr. 6794:15-25, Vavra Tr. 13883:19-13884:16, 13898:14-13899:2, McMahon Tr.*  
16 *15661:13-20, McNabb Tr. 19771:16-20, 19827:4-19828:4, 20795:6-11, Murray Tr. 13679:5-*  
17 *13679:19*)

18           114. Months before the Merger was announced, PLHIC had already planned to automate  
19 and outsource its incoming mailroom and document routing functions to a vendor ACS.  
20 (*Murray Tr. 3165:12-3166:13, Vavra Tr. 13886:3-11; Exh. 5443*)

21           115. Indeed, outsourcing mailroom operations to a vendor is consistent with industry  
22 standard. (*McNabb Tr. 19771:16-19772:15, Vavra Tr. 13881:7-16*)

23           116. Post-Merger, PacifiCare and United analyzed whether to proceed with this  
24 automation plan using either Lason and ACS. (*Vavra Tr. 13892:5-12*)

25           117. Based on comparisons of historical performance and experience with both vendors,  
26 PLHIC and United decided to proceed with Lason because of its superior performance. (*Exhs.*  
27 *5454, 5455, 5615, p. 6; Vavra Tr. 13887:22-13888:17, 13889:11-22, 13892:5-13895:21,*  
28 *13896:18-13897:12*)

1 118. Moreover, Lason, like United, utilized “Six Sigma” processes and trained  
2 personnel, which permitted it to more efficiently co-develop process improvements in the  
3 document routing and management functions it performed for PacifiCare and United. (*Murray*  
4 *Tr. 3234:17-3235:3*) As a result, Lason was also able to engage in quarterly Six Sigma projects  
5 with United and PacifiCare, which was another reason PacifiCare/United chose Lason over ACS.  
6 (*Vavra Tr. 13896:18-13897:12; Exh. 5458*)

7 119. PacifiCare used a team of subject matter experts, led by a PacifiCare legacy  
8 employee, to design a system that would be tailored to PacifiCare’s needs and spent months both  
9 in its design and testing. (*Murray Tr. 13679:25-13680:12, 13712:14-13715:25, 13770:17-*  
10 *13773:13, 14345:8-14347:10, Vavra Tr. 13900:4-13900:24, McNabb Tr. 19829:8-17*)

11 120. In connection with the design of the automated mailroom system, the PacifiCare  
12 team spent weeks documenting existing processes and procedures and, in that regard, conducted  
13 extensive interviews with the mailroom staff. (*Murray Tr. 13681:19-13684:5; Exh. 5444*)

14 121. From the outset, the design represented a substantial simplification and  
15 improvement over the routing system in place prior to the Merger. (*Berkel Tr. 7456:24-7458:12,*  
16 *Murray Tr. 3165:2-3166:13, 3200:4-3201:21, Vavra Tr. 13885:19-13886:25; Exh. 5468*)

17 122. The resulting design significantly simplified the company’s handling and decision-  
18 making, reducing the 69 previously required “decision groups” to 6 and the 86 legacy  
19 “document types” to 63 document types. (*Exhs. 5468, 5469; Murray Tr. 14384:7-14388:5*)

20 123. Lason’s digital delivery of paper mail also eliminated the need to manually deliver  
21 paper to the 163 previously required “destinations.” (*Murray Tr. 14386:3-17; Exhs. 5468, 5469*)

22 124. When it began service in April 2006, Lason accurately routed over 98% of  
23 PacifiCare’s Regional Mail Office correspondence. (*Exh. 5457; Vavra Tr. 13927:6-21*)

24 125. For the first time, in July 2006, PacifiCare management gained visibility into its  
25 correspondence routing using Lason’s “DocDNA” system. (*Murray Tr. 3200:3-3200:24,*  
26 *13718:5-13719:5*)

27 126. Later in 2006, Lason implemented a “work flow” system into DocDNA that  
28 permitted individual users to control the routing of documents and allowed PacifiCare to

1 examine the processing history of every document, which further increased the company’s  
2 reporting capability. (*Murray Tr. 3200:3-3201:24*)

3 127. Lason also made steady improvements in accuracy over the next two years,  
4 resulting in an accuracy rating of approximately 99.5% by 2009. (*Exh. 5457*)

5 128. CDI does not link any Lason-related issue to any specific violation alleged in this  
6 hearing. Deputy Commissioner Cignarale admitted he could not “say for certain how many . . .  
7 alleged violations were caused by Lason” and he had “no idea” how many claims were paid late  
8 due to the Lason transition, while Mr. Boeving admitted he made no effort to, and could not,  
9 “link a mistake in the integration” to any alleged violation. (*Cignarale Tr. 22888:7-22892:10*,  
10 *Boeving Tr. 19143:7-19145:14; Exh. 5593*)

11 6. Accenture

12 129. Pre-Merger, PLHIC’s Member Accounting Services (“MAS”) was responsible for  
13 member eligibility enrollment, including the manual entry of data from paper enrollment forms  
14 into PLHIC’s systems, case installation, setting up new employer groups, and billing functions.  
15 (*Watson Tr. 17644:4-11*)

16 130. PLHIC’s legacy processes and procedures surrounding member enrollment and  
17 data entry relied on undocumented business practices, special handling rules and non-  
18 standardized forms, which Ruth Watson agreed “complicated the process.” Rather than using  
19 standardized forms, PLHIC forms were “often handwritten . . . Every municipality, every  
20 company ha[d] their own form. And we did not standardize that.” (*Watson Tr. 17681:8-12*,  
21 *17788:3-13*)

22 131. She agreed that “standardizing forms simplifies and eliminates error,” and “is a  
23 good practice,” but conceded that prior to the Accenture transition, her team “had not made  
24 efforts to standardize the forms.” (*Watson Tr. 17788:3-17789:6*, *Lippincott Tr. 16383:16-*  
25 *16384:7*)

26 132. After the Merger, the Company set about standardizing the eligibility process to  
27 minimize error and made the decision to outsource the data processing function to a third vendor.  
28 (*Watson Tr. 17672:19-17673:5*, *17681:3-17682:1*, *17788:3-17789:9*)

1 133. PLHIC’s integration expert explained that during the “‘05-’06 time frame, there  
2 was a big wake-up call for the industry around [outsourcing eligibility data entry] as a best  
3 practice,” and a “push for standardization of forms and getting away from special handling  
4 forms.” (*McNabb Tr. 20794:10-20795:13*)

5 134. PLHIC had planned, pre-Merger, to automate and outsource the data entry of  
6 member enrollment information to a vendor, ACS, and Ms. Watson was involved in and  
7 supported that decision. (*Watson Tr. 17739:1-8, Vavra Tr. 13885:13-13887:4, McNabb Tr.*  
8 *20796:2-11*)

9 135. The third party vendor ultimately selected, Accenture, is one of the world’s most  
10 well known and respected consulting companies, and had a track record of successfully handling  
11 this data entry function for United at a lower cost. (*Labuhn Tr. 5493:19-5494:2, 5569:14-*  
12 *5571:23, 5493:19-5494:2, Berkel Tr. 7818:1-6, McNabb Tr. 19833:22-19834:4; Exh. 540;*  
13 *Watson Tr. 17739:13-20, Wichmann Tr. 18457:13-18*)

14 136. The outsourcing of data entry functions to an experienced vendor such as  
15 Accenture was not only reasonable at the time, but an industry standard practice for improving  
16 quality, standardizing procedures previously subject to undocumented and special handling rules,  
17 and reducing health care costs. (*Exh. 5615, pp. 6-7; McNabb Tr. 20794:24-20795:13, 19833:6-*  
18 *19834:4*)

19 137. Prior to implementing the transition to Accenture, the Company undertook  
20 significant diligence in order to understand and document existing processes. (*Watson Tr.*  
21 *17774:18-17776:14, McNabb Tr. 19835:6-11*)

22 138. Ms. Watson testified that as part of the Accenture transition, United personnel  
23 traveled to Cypress for six weeks where “they interviewed staff,” “sat and watched processes,”  
24 and “diagrammed processes.” (*Watson Tr. 17680:18-20, 17774:18-17776:14, McNabb Tr.*  
25 *20773:25-20774:16, 19835:6-11*)

26 139. PLHIC also sent a dedicated subject matter expert on eligibility to Accenture to  
27 prepare for the transition. (*Watson Tr. 17776:5-19*)

28

1 140. PLHIC also implemented a months-long pilot program to test the Accenture  
2 transition before implementing the function and concluded that it “exceeded [PLHIC’s]  
3 expectations for quality and efficiency.” (*Labuhn Tr. 5488:5-15, 5499:6-20, Watson Tr.*  
4 *17772:24-17773:18; Exhs. 539, 540*)

5 141. Ms. Watson admitted that she believed the testing associated with the pilot was  
6 adequate, and that she did not express complaints about things that she believed should have  
7 been done. (*Watson Tr. 17743:1-21, 17745:24-17746:19, 17773:1-11; Exh. 283*)

8 142. Problems associated with the Accenture transition resulted from special handling  
9 rules and longstanding exceptions that were not communicated to the United team. Ms. Watson  
10 admitted that her team had “special handling or special things that were being done for certain  
11 accounts” “that the Accenture team was not aware of “ that “caused them to make mistakes,”  
12 even though the “Accenture team was processing the eligibility forms according to standard  
13 processes and procedures” “provided by [Ms. Watson’s] department.” (*Watson Tr. 17678:4-18,*  
14 *17780:2-17781:11*)

15 143. When asked why the special handling rules had not been documented, Ms. Watson  
16 conceded that “they should have been documented.” (*Watson Tr. 17781:12-20*)

17 144. When United personnel involved in training Accenture interviewed legacy  
18 PacifiCare staff, they were told “there were no special handling” rules, when “in fact, there  
19 [were].” (*Watson Tr. 17678:5-13*)

20 145. Although CDI and Ms. Watson have characterized the manner in which PLHIC  
21 handled Group Services functions pre-Merger as “high touch,” Ms. Watson admitted that one  
22 reason PLHIC had to employ a “high touch” approach was due to errors made by employer  
23 groups and members resulting from non-standardized enrollment forms processes. (*Watson Tr.*  
24 *17681:3-20, 17705:3-11, 17806:18-17807:12*)

25 146. Indeed, the “high touch” model that PLHIC used pre-Merger, as described by Ms.  
26 Watson and other PLHIC witnesses, was not a positive service model and created business risk  
27 for the organization. (*Exh. 5615, p. 7*)  
28

1 147. The disruption caused by the transition to Accenture was temporary in nature and  
2 service improved within months. (*Watson Tr. 17777:13-17778:1*)

3 148. CDI has not presented any evidence tying any of the eligibility data entry issues  
4 that may have arisen following the Accenture transition to any specific alleged violation in this  
5 proceeding.

6 149. CDI's testimony about the alleged impact from the transition is "anecdotal" at best  
7 and CDI did not present any evidence of a single member having been denied medical care, or of  
8 claims not being paid, as a result of the Accenture transition. (*Exhs. 1040, 1041; Watson Tr.*  
9 *17795:24-17801:1, 17806:5-17*)

10 150. The one anecdotal example of an issue that arose following the Accenture  
11 transition involved members who were inadvertently terminated due to the failure of legacy  
12 PLHIC employees to explain special handling rules to the Accenture staff. (*Berkel Tr. 7816:7-*  
13 *23, 10412:7-10413:2*). The issue was quickly resolved and there was minimal, if any, impact to  
14 members. (*Berkel Tr. 7817:2-8, 10413:23-10415:7*)

15 7. EPDE - "Electronic Provider Data Extract"

16 151. CTN's early termination of access to its network created a situation where one  
17 provider network in California was supported by two databases (United's NDB and PLHIC's  
18 RIMS) which required separate, dual maintenance. (*Exh. 5615, p. 8-9*)

19 152. "Dual maintenance" of provider data introduces the risk of inconsistent data caused  
20 by inputting the data twice as well as other errors and presents a risk management problem.  
21 (*McNabb 19811:19-19812:14, Lippincott Tr. 14996:17-14997:03, Berkel Tr. 8230:17-24,*  
22 *McFann Tr. 10649:12-19; Exh. 5486*)

23 153. Industry historical experience has demonstrated that dual maintenance of provider  
24 demographic data is "hard to control." Over time, the data "starts unraveling and becomes  
25 inconsistent again due to . . . inconsistent data structures and definitions and human  
26 interpretation . . ." (*McNabb Tr. 19812:7-14, 21361:5-16*)

27 154. Given these risks, the company decided to establish a combined single "source of  
28 truth" for California provider demographic data that would be updated in United's Network

1 Database (“NDB”). (*Lippincott Tr. 14986:2-5, McNabb Tr. 19881:2-10, Boeving Tr. 19299:24-*  
2 *19300:4*)

3 155. Choosing a single source of truth for provider data was a reasonable decision under  
4 the circumstances and is considered an industry best practice. (*Exh. 5615; McNabb Tr. 19811:6-*  
5 *19812:14, 21335:17-25, 23177:24-21378:1*)

6 156. PacifiCare and United chose NDB over RIMS as the single source of truth because  
7 NDB was a long term asset of United, and United had been “paying claims for [the] same  
8 providers for over a million United members,” with “a much higher level of claim payment  
9 activity on the NDB database” in comparison with RIMS for the same providers. (*Lippincott Tr.*  
10 *14999:21-15000:14*)

11 157. Additionally, some PacifiCare employees working with the [EPDE team] expressed  
12 concerns about the accuracy of provider demographic information in the RIMS database. (*Exh.*  
13 *5486; Lippincott Tr. 14999:21-15001:14, 15067:18-15068:7*)

14 158. In four prior integrations, NDB had proven that it could function as a source of  
15 truth for provider data sets. (*Lippincott Tr. 15003:21-25; Exh. 5486, p. 4*)

16 159. In order to communicate any updates to RIMS, United utilized a data bridge which  
17 is a standard tool amongst health insurers to replicate provider demographic data between  
18 separate claims systems. (*Exh. 5615, p.9; McNabb Tr. 19813:20-19814:25, Boeving Tr.*  
19 *19703:13-25*)

20 160. The particular data bridge United utilized, EPDE, had a proven track record in  
21 other integrations and provider data information exchanges dating as far back as 2002.  
22 (*Lippincott Tr. 15003:10-15005:12, 15007:10-17; Exh. 5486, p. 4, Exh. 5615, p.8*)

23 161. Prior to implementing the transition to a “single source of truth” for RIMS data, the  
24 Company compared the data in the two systems and resolved any discrepancies in data between  
25 them and undertook substantial testing of the system before it went live. (*Lippincott Tr.*  
26 *15010:18-15014:21, 16106:18-16108:7, 15006:24-15007:9, McNabb Tr. 20400:19-25; Exh.*  
27 *5486, p. 5*)

28

1           162. Mr. Lippincott testified that EPDE’s design and deployment was executed by over  
2 “100 individuals,” including experienced subject matter experts from both PacifiCare and United  
3 during “each and every one of [the implementation] steps,” who provided full system support  
4 during and after the implementation. Mr. Lippincott explained that the legacy PacifiCare  
5 employees were critical to the transition because “[t]hey were the experts at the RIMS database,  
6 understood the data structures, the way the data would operate . . . they were a critical  
7 component of designing and deploying this process.” (*Lippincott Tr. 15013:24-15014:21,*  
8 *14987:16-21*)

9           163. Deployment of the system followed a “fairly standard deployment timeline” for  
10 such a project. (*Lippincott Tr. 15009:4-15*)

11           164. The Company engaged in ongoing system and data monitoring processes to detect  
12 any potential problems, including routine war room meetings, reconciliation reports, examination  
13 of EPDE changes and errors on a daily basis and regular PHS IT involvement. (*Lippincott Tr.*  
14 *15016:22-15018:13, 15022:20-15024:1, 15095:16-23, 17318:7-13, 14986:20-14987:5, 14989:5-*  
15 *12; Exhs. 968, 5601, 5486, p. 7, 5615, p. 9*)

16           165. That issues arose following implementation of EPDE were not unexpected or  
17 unusual; PLHIC and United witnesses testified that provider demographic data maintenance is  
18 inherently more challenging than with other types of data because health plans must rely upon  
19 providers to inform the plan of changes to their demographic data. (*McNabb Tr. 19811:25-*  
20 *19813:16, Lippincott Tr. 17306:21-17307:10, McFann Tr. 10683:6-13, 10684:4-8, Cignarale*  
21 *Tr. 23685:1-12*)

22           166. The complexities with maintaining accurate provider demographic data can be even  
23 more challenging for medical groups where credentialing responsibilities are delegated by the  
24 provider to the medical group’s administrators, adding another level of interaction where errors  
25 and omissions can occur. (*McFann Tr. 10683:9-10684:3, 12958:22-12959:12*)

26           167. Over time, the combined companies made improvements to the provider  
27 demographic data entry and maintenance systems. (*McFann Tr. 12955:25-12956:7; Exh. 5404*)  
28

1           168. PacifiCare and United’s continuing efforts to standardize their provider  
2 demographic maintenance processes is evidenced by United’s high ranking in recent provider  
3 surveys for claim payment accuracy, including the 2011 AMA Health Insurer Report Card, with  
4 “UnitedHealthcare [coming] out on top of seven leading commercial health insurers,” and  
5 “Anthem Blue Cross Blue Shield” with the “worst of those measure[d].” (*Exh. 5615, p.5*)

6           169. While CDI cites the existence of returned checks as evidence that EPDE caused  
7 late-paid claims, the evidence presented at trial is to the contrary; PLHIC experienced fewer  
8 returned checks after implementing the EPDE process than in the months prior. (*Lippincott*  
9 *17306:12-17310:9, Boeving Tr. 19409:2-19411:19; Exh. 604*)

10           170. Mr. Lippincott’s unrebutted testimony was that based on his experience and review  
11 of the issues, he was not aware of EPDE-related issues ever having caused a single late-paid  
12 claim. Also, CDI’s integration expert Boeving did not link any EPDE issue to a violation alleged  
13 in this proceeding, nor did he quantify the impact of any alleged issues. (*Lippincott Tr.*  
14 *17324:13-19; see also Boeving Tr. 19200:21-19201:10*)

15           8. UFE

16           171. Post-Merger, PacifiCare and United sought, where possible, to apply consistent  
17 technological systems and processes across platforms, a strategy PLHIC’s expert Rick McNabb  
18 testified was an industry best practice. (*McNabb Tr. 21335:17-21336:2, 21377:24-21378:1 (re:*  
19 *EPDE, single source of truth)*)

20           172. The Company took this approach with regard to the receipt of electronically  
21 submitted claims (EDI) from various trading partners. (*Soliman Tr. 16992:17-16993:11,*  
22 *15366:25-15367:1, Way Tr. 14253:7-13; Exh. 5524*)

23           173. Pre-Merger, PacifiCare processes for submitting EDI claims required more manual  
24 attention and special handling because PacifiCare did not have a standardized process for  
25 submitting claims. (*Soliman Tr. 15365:25-15366:18, 15373:10-13*)

26           174. As a result, in late 2006, the Company implemented a more standardized process  
27 for receiving EDI claims, the United Front End (“UFE”) system. (*Soliman Tr. 15367:3-7,*  
28 *16992:17-16993:11*)

1           175. Upon receipt of EDI claims from trading partners, UFE would route the claims to  
2 either a PacifiCare or United gateway. *(Soliman Tr. 15367:11-16)*

3           176. After arriving at the PacifiCare or United gateway, a claim would then be routed to  
4 the appropriate claims platform (e.g., RIMS, NICE, ILIAD or OTIS for PacifiCare or UNET for  
5 United). *(Soliman Tr. 15373:22-24)*

6           177. Although some issues arose following implementation of the UFE system for  
7 PacifiCare claims, CDI has not linked any such issues to a specific violation alleged in this case,  
8 and the evidence presented in the hearing confirmed the impact, if any, was minimal.  
9 *(Vonderhaar Tr. 6813:21-6814:15 (impact was limited), 6273:16-20 (while claims may have*  
10 *been on UFE for a longer period of time as a result of the gateway issue, the issues did not have*  
11 *a material impact on claims handling), 6813:16-20 (UFE only affected EDI claims, not paper*  
12 *claims), 6264:22-6266:21 (short term claims routing issues did not affect overall claims payment*  
13 *turnaround time metrics), Boeving Tr. 19200:21-19201:10)*

14           178. CDI alleges that issues arising out of the UFE transition were the result of  
15 inadequate funding for testing prior to UFE’s launch. To support this allegation, CDI points to  
16 the testimony of former PLHIC employee Ms. Soliman who claimed that her requests for  
17 funding were often denied. *(Soliman Tr. 15382:6-15383:6, 16996:3-8)*

18           179. CDI did not present any documentary evidence to support Ms. Soliman’s claims.  
19 PacifiCare, however, established through contemporaneous budgeting emails and documents that  
20 when Ms. Soliman requested additional funding and resources for a UFE-related project, her  
21 business managers directed her to “ensure work continu[es] while this internal costing issue is  
22 being resolved expeditiously,” and that her “estimate [seeking additional funding and resources]  
23 was approved.” *(Soliman Tr. 17005:16-17006:10, 17009:18-24; Exhs. 5525, 5527, 5528)*

24           9. Customer Service

25           180. PLHIC’s Marty Sing, head of PLHIC and PCC’s customer service centers from  
26 June 2004 to the present, testified extensively concerning the staffing and training of PLHIC’s  
27 PPO call centers both pre- and post-Merger. *(Sing Tr. 9403:16-9405:4)*

28

1           181. Mr. Sing testified that new customer service representatives (“CSRs”) on his teams  
2 undergo a multi-week training session that includes classroom learning, familiarization with the  
3 various claims systems, and weeks of parallel live-training where trainees answer actual  
4 customer and provider calls with a trainer or supervisor sitting next to them. (*Sing Tr. 7186:17-*  
5 *7188:7*)

6           182. Mr. Sing testified that although PLHIC had auditing processes pre-Merger, United  
7 introduced a “far more rigorous” auditing process, “far more stringent” goals, and new  
8 procedures, from “defect measurement,” or focusing on the accuracy of information provided by  
9 CSRs to “focused audits,” “a secret shopper program,” and “[d]aily feedback on individual  
10 evaluations.” (*Sing Tr. 7202:1-7202:19, 7203:6-15, 7204:11-7205:13*)

11           183. Mr. Sing testified to and introduced several exhibits detailing the post-Merger  
12 auditing procedures used by PLHIC to ensure that CSRs are professional, provide accurate  
13 information, and respond to customer needs. (*Sing Tr. 7198:2-7200:8, 7207:17-7211:1; Exhs.*  
14 *5245, 5246, 5247*)

15           184. For example, Mr. Sing explained how reviewers regularly listen to pre-recorded  
16 calls taken by CSRs and review their contemporaneous computer screen activity to ensure that  
17 the CSR is accessing the correct systems and providing the correct information to the caller.  
18 (*Sing Tr. 2534:16-2535:7, 3420:14-3421:14, 7200:17-7201:4*)

19           185. On the issue of claims status acknowledgement, whenever a provider calls asking  
20 generally about a claim, PLHIC PPO CSRs are trained to provide claims status, including  
21 specifically, the date a claim was received, and its processing or payment status (providers are  
22 not required to ask about claims acknowledgment to receive such information). (*Sing Tr.*  
23 *7193:11-7195:19*)

24           186. PLHIC witnesses demonstrated through the use of training materials that it is  
25 PLHIC’s express policy to train its CSRs to look up and provide the received date of a claim  
26 when responding to general inquiries concerning claims status. (*Sing Tr. 7192:12-7195:19,*  
27 *Murphy Tr. 13562:17-13564:11; Exhs. 5136, 5244*)

28

1 187. PLHIC received over two hundred thousand inquiries in 2006 and 2007 concerning  
2 claims status, which demonstrates that providers utilized PLHIC’s phone systems to access  
3 information on claims, and rebuts CDI’s inference that providers did not know how to call  
4 PLHIC to obtain claims status information. (*Sing Tr. 7184:4-7186:16; Exh. 5243*)

5 **II. THE CDI’S INVESTIGATION, EXAMINATION AND ENFORCEMENT**  
6 **ACTION AGAINST PLHIC**

7 **A. CDI’s Investigation of PLHIC**

8 188. It is undisputed that a number of significant provider interests lobbied regulators to  
9 take action against PLHIC and United during the period of re-contracting that followed the CTN  
10 termination. (*Monk Tr. 9160:15-9161:5, Wetzel Tr. 16869:15-16872:10, Black Tr. 1212:3-17,*  
11 *Cignarale Tr. 24027:21-24034:22, Griffin Tr. 2634:4-10; Exhs. 165, 5507, 5082, 5297, 5414,*  
12 *5684, 5685*)

13 189. The California Medical Association (CMA), an influential trade association  
14 representing doctors in California, took an active role in lobbying CDI. Aileen Wetzel, an  
15 Associate Director with CMA, testified to “cultivating” a relationship with Andrea Rosen and  
16 other key CDI staff in connection with PLHIC. (*Wetzel Tr. 16789:15-23, 16790:3-19,*  
17 *16790:23-16792:5, 16799:17-16800:4, 16801:1-16803:2, 16866:14-16868:4, Kessler Tr.*  
18 *20960:6-11; Exh. 5622, p. 35 re Capital Weekly’s Top 100 most influential players in California*  
19 *politics*)

20 190. Indeed, CMA’s first meeting with CDI preceded any investigation of PLHIC, even  
21 by Consumer Services Bureau Staff. (*Exh. 5507; Wetzel Tr. 16818:13-16819:17, 16820:12-18*)

22 191. CDI staff repeatedly met with CMA to discuss PLHIC in the early stages of CDI’s  
23 investigation of PLHIC, well before CMA had filed a complaint against the Company, and CDI  
24 staff continued to meet with CMA and provide updates throughout the investigation. (*Exhs.*  
25 *5507, 5508, 5509, 5511; Wetzel Tr. 16800:1-16802:17, 16809:2-21, 16812:1-17, 16812:25-*  
26 *16817:10, 16820:15-16824:13, 16854:8-16857:22*)

27 192. CDI’s stated reasons for beginning its investigation of PLHIC are not supported by  
28 the evidence in the record. CDI relies on an “influx” of provider complaints in late 2006 as  
justification for CDI’s investigation of PLHIC, but the record shows that for the three months

1 from October 1, 2006 to January 1, 2007, only eight providers complained about PLHIC, for  
2 which CDI cited PLHIC with no violations. (*Exh. 5720*)

3 193. CDI’s Nicoleta Smith also testified that she attempted to reach PLHIC personnel in  
4 October and November 2006, but the phone kept “ringing and ringing,” and claimed it was  
5 “December . . . when I received a call back,” but on cross-examination, she admitted that she  
6 spoke with a PLHIC representative on November 2, 2006. (*Smith Tr. 55:19-56:8, 184:10-*  
7 *185:21*)

8 194. Although CDI asserts it had concerns about PLHIC in Fall 2006, it did not  
9 communicate any concerns in writing until January 11, 2007, prior to which time PLHIC already  
10 had assembled a corrective action team to address certain performance issues. (*Smith Tr. 188:9-*  
11 *14; Exh. 5004*)

12 195. Prior to, during and after the 2007 MCE, PLHIC self-disclosed a number of issues  
13 facing the Company including its incorrect application of a 12 month pre-ex exclusionary period.  
14 (*Exhs. 8, 163, 5169; Berkel Tr. 9778:25-9779:11, 7568:8-15, Smith Tr. 126:21-127:6, 160:10-*  
15 *22, 207:19-210:16, 221:7-222:7, Laucher Tr. 13062:4-8*)

16 196. Throughout Spring 2007 and prior to the 2007 Market Conduct Exam (“2007  
17 MCE”), CDI requested substantial, additional data from PLHIC, including: claims reprocessed as  
18 a result of PLHIC having applied a 12 month pre-ex exclusionary period, (*Exh. 5348*), data for  
19 claims reprocessed because of provider demographic and fee schedule issues, (*id.*), material  
20 describing PLHIC’s provider outreach and education initiatives (*id.*), PLHIC’s handling of  
21 issues regarding creditable coverage, (*Smith Tr. 58:1-10, 62:25-63:18*), information concerning  
22 PacifiCare Life Assurance Company (a licensee for PacifiCare’s PPO business outside of  
23 California), (*Exh. 9*), training certification details, (*id.*), details regarding staffing changes, (*Exh.*  
24 *5*), phone answering and voice mail policies, (*id.*), contract loading processes, (*Exh. 5259*),  
25 procedures related to PacifiCare’s maintenance of fee schedules. (*id.*), contract negotiation  
26 processes, (*id.*), contract data tools, (*id.*), the mechanics of provider demographic data handling,  
27 (*id.*), details of the CTN network transition, (*McFann, Tr. 10772:16- 10773:4, Berkel 7549:18-*  
28 *7550:23, 7572:2-15; Exh. 8*), details regarding contracts executed with retroactive effective

1 dates, (*Exh. 5372*), as well as all aspects of contract data used by PacifiCare claims systems.  
2 (*id.*)

3 197. PLHIC agreed to remediate, and was in the process of remediating, or had  
4 completed remediating, all of the issues both CDI and PLHIC had identified by the end of April  
5 2007.

6 **B. The 2007 Market Conduct Exam**

7 198. On May 14, 2007, CDI notified PLHIC of its intention to commence a targeted  
8 examination of PLHIC for the period June 22, 2006 through May 31, 2007 (the “2007 MCE  
9 Period”) despite PLHIC having agreed to work with CDI and remediate all issues of concern.  
10 (*Exh. 5372*)

11 199. CDI focused on the same time period that had already been the subject of its Spring  
12 2007 investigation, where it knew it would find problems instead of examining whether PLHIC’s  
13 remediation was successful.

14 200. In the 2007 MCE, CDI applied an unprecedented approach to the examination by  
15 looking examining the entire population of paid claims, rather than a sample. (*Dixon Tr.*  
16 *5156:20-5157:22*)

17 201. CDI contemplated making United a subject of the 2007 MCE as well, but elected  
18 instead to settle any potential claims against United as part of a multi-state settlement (the  
19 “United MAWG”) and imposed a limited penalty of \$246,000 penalty. (*Laucher Tr. 13131:6-*  
20 *13134:5, 13135:21-13137:7; Exhs. 5291 and 5292*)

21 202. At the time, a routine, non-targeted examination of PLHIC dating back to 2006 (the  
22 “2006 Routine Exam”) was still underway but CDI had yet to issue a draft report on the results  
23 of that examination. (*Exh. 116, pp. 1375-1410*)

24 203. Prior to commencement of the 2007 MCE, CDI’s Market Conduct Division  
25 requested substantial information from PLHIC, including detailed data for all claims closed over  
26 the course of one year, (*Exh. 105; David Tr. 11434:18-11438:20*), data describing multiple  
27 characteristics of complaints filed by consumers for one year and data describing all provider  
28 disputes filed with the company for one year, (*Exh. 5045*), the identity of management

1 “responsible” for a wide variety of company operational areas, (*id.*), detailed information  
2 regarding the specific employees performing claims handling activities, (*id.*), information  
3 describing the company’s claims audit procedures, (*Exhs. 104, 105; Vandepas Tr. 750:21-*  
4 *752:23*), extensive data for providers on the United network who also gave network access to  
5 PLHIC, data for all contracts effective during a one year period, (*id.*), and descriptions of the  
6 company’s claim unbundling and downcoding procedures. (*id.*)

7 204. The on-site portion of CDI’s exam began on July 23, 2007. (*Exh. 5373, p. 6118*)

8 205. During the 2007 MCE, CDI continued to request substantial amounts of  
9 information from PLHIC, and sent PLHIC an unprecedented 274 referrals over a three month  
10 period. (*Valenzuela Tr. 1187:25-1188:6*) This volume of referrals is several times greater than  
11 the number of referrals that CDI typically propounds on other insurers. (*Dixon Tr. 5272:12-*  
12 *5273:2*)

13 206. CDI sent many referrals asking PLHIC about matters that CDI knew had been  
14 identified and remediated by the company many months before (e.g., the 12 month pre-existing  
15 exclusionary period, “Pre-Existing Procedures Group General Inquiry” (9/10/07), notice of right  
16 to CDI review on provider EOPs, “Denial EOBs do not meet the requirements of CIC  
17 §10123.13(a)” (9/18/07), notice of IMR rights on EOBs, “Group Provider Dispute” (8/30/2007)  
18 (*Valenzuela 1190:14-11191:13; Exh. 5065*)). PLHIC responded to 261 of the 274 referrals  
19 before or on the requested date for completion. (*Valenzuela Tr. 1186:20-1188:6, 1190:8-21,*  
20 *1192:6-1194:4, Berkel Tr. 7607:18-7609:3; Exh. 5065*)

21 207. CDI ended the 2007 MCE on November 8, 2007. (*Exh. 155*)

22 **C. Draft 2007 MCE Findings and PLHIC’s Response**

23 208. On November 7, 2007, CDI sent PLHIC draft reports for the 2007 MCE. (*Exh.*  
24 *116*)

25 209. Although CDI had completed the separate 2006 Routine Exam months before, it  
26 only provided the draft reports for that exam to PLHIC on November 7, 2007. (*Exh. 116*)

27 210. The draft reports for the 2006 Routine Exam and the 2007 MCE consisted of two  
28 separate reports: a “public report” under Insurance Code section 12938 and a “confidential

1 report” under Insurance Code section 735.5. CDI allowed PLHIC only thirty days to respond to  
2 all four draft reports. (*Berkel Tr. 7628:12-7632:5, Dixon Tr. 5292:3-9*)

3 211. CDI staff testified that they were under significant time pressure by management to  
4 complete the four reports. (*David Tr. 11624:2-11626:7, Vandepas Tr. 932:22-933:17*)

5 212. On December 7, 2007, Susan Berkel, a senior PacifiCare executive, timely served  
6 draft responses on behalf of PLHIC to all four draft reports. (*Exhs. 117, 118*)

7 213. The statements contained in PLHIC’s responses to the draft reports for the 2007  
8 MCE (the “December 2007 Berkel Letters”) do not have significant probative value on the  
9 merits of CDI’s allegations.

10 214. The Court finds that Ms. Berkel provided candid and thoughtful testimony about  
11 her approach to responding to CDI’s draft reports, and that Ms. Berkel accepted as true many of  
12 CDI’s contentions, including the number of claims allegedly paid late and whether an insurer  
13 must send a letter acknowledging receipt of a paper claim in an effort to meet CDI’s expectations  
14 and resolve the pending issues between PLHIC and CDI. (*Berkel Tr. 7632:15-7635:23,*  
15 *10094:9-18*)

16 215. As it turns out, Ms. Berkel agreed to findings that CDI itself no longer contends are  
17 correct. (*Exh. 102 (withdrawing 7,203 late paid claims allegations); see also Exhs. 117, 118,*  
18 *1209; Cignarale Tr. 23814:18-23822:16 (CDI withdrew allegations as to late paid claims and*  
19 *claims acknowledgments), Cignarale Tr. 23826:13-17*)

20 216. PLHIC did not agree, in the December 2007 Berkel Letters or otherwise, that the  
21 violations at issue constituted unfair settlement practices pursuant to Section 790.03; nor did CDI  
22 make such a contention at the time. (*Exhs. 1, 116, 117, 118; Berkel Tr. 7780:5-7782:16*)

23 217. PLHIC made clear in its written response to the final examination reports that:  
24 “[a]ny problems that did occur were neither knowingly committed nor part of a general business  
25 practice. Therefore, PacifiCare disputes each and every alleged violation of **CIC Section 790.03**  
26 and California Code of Regulations section 2695 et seq. as set forth in the Public Report.” (*Exhs.*  
27 *164, 5189; Dixon Tr. 5297:12-5298:13*)  
28

1                   **D. Enforcement Action/Charging Allegations**

2                   218. In late January 2008, CDI announced that it had initiated an enforcement action  
3 against PLHIC relating to the 2007 MCE and published both the Public Report and the  
4 Confidential Report (collectively, the “2007 Examination Reports”). (*Exhs. 1 at Exhibits 1 and*  
5 *2; see also Exh. 5272*)

6                   219. At the time CDI completed the 2007 Examination Reports, it concluded that  
7 alleged violations related to (1) the failure to include certain language on PLHIC’s form  
8 Explanation of Benefits (“EOBs”) and Explanation of Payments (“EOPs”), (2) the failure to send  
9 written letters acknowledging receipt of paper claims, (3) the payment of claims beyond the 30  
10 working day standard, (4) the failure to pay interest on late paid claims, and (5) the denial of  
11 claims on the basis of the pre-existing condition exclusion (collectively, the “Principal Alleged  
12 Violations”), were “something other than violations of Section 790.03.” (*Exh. 116*)

13                   220. CDI identified only ninety (90) violations of Insurance Code sections 790.03 and  
14 790.035 in its Public Report pursuant to [Section 12938\(b\)](#). (*Exhs. 1, 116*)

15                   221. Senior CDI management, including Tony Cignarale and Joel Laucher, reviewed  
16 and approved the 2007 Examination Reports prior to their publication and release. (*Exhs. 892,*  
17 *5655; Laucher Tr. 14075:8-24, Cignarale Tr. 23011:8-20*)

18                   222. On January 28, 2008, CDI served an Order to Show Cause (the “OSC”) on PLHIC  
19 in connection with the conclusions arising out of the 2007 Examination Reports and did not  
20 charge the Principal Alleged Violations as violations of Section 790.03. (*Exh. 1*)

21                   223. In June 2009, CDI requested a hearing on the OSC.

22                   **III. CDI’S ENFORCEMENT ACTION HAS BEEN PROSECUTED IN AN**  
23 **ARBITRARY MANNER**

24                   224. A regulated entity must be afforded certain basic protections by its regulator that  
25 include the application of objective standards and processes for ensuring that the regulated entity  
26 is treated fairly.

27                   225. PLHIC’s regulatory expert Sue Stead provided compelling testimony concerning  
28 the appropriate manner and objectivity with which insurance regulators should investigate,

1 examine and regulate insurers within their jurisdiction. (*Stead Tr. 24270:25-24271:20,*  
2 *24365:21-24367:10, 25869:17-24, 25939:22-25940:4; Exh. 5712, p. 2-6)*

3 226. CDI's mission statement, as well as the testimony of CDI senior management,  
4 corroborates Ms. Stead's conclusions regarding the importance of maintaining the regulatory  
5 process in an open and equitable manner and enforcing the law fairly and impartially. (*Exhs.*  
6 *5407, 5411; Laucher Tr. 13178:24-13180:18, 13183:4-13184:8, Cignarale Tr. 23738:3-*  
7 *23741:21)*

8 227. The Court found Ms. Stead to be well qualified to offer the opinions that she  
9 provided in this hearing. Ms. Stead spent over half her career as an insurance regulator with  
10 direct responsibility and experience handling issues involved in this proceeding, including  
11 oversight of market conduct examinations, investigations and enforcement actions. The other  
12 half of Ms. Stead's professional career has been in private practice, where she has continued to  
13 interact with insurance regulators, including regulators at CDI, regarding compliance matters and  
14 has advised insurance clients in California. Based on her experience in both her government and  
15 private practice, Ms. Stead has gained familiarity with health care insurance legislation,  
16 including the operative statutes involved in this proceeding.

17 228. Ms. Stead also has extensive involvement in industry professional organizations  
18 responsible for creating many of the standards that insurance regulators around the country have  
19 adopted, most notably her involvement in the NAIC (including chairing the committee that  
20 authored the NAIC's Market Conduct Annual Statement), her service as past Chair of the  
21 American Bar Association's Committee on Insurance Regulation and serving as Vice Chair on  
22 the IRES Foundation Board, an industry education group for insurance regulators.

23 **A. No Written Standards**

24 229. No written rules or guidelines support CDI's interpretations of nearly all of the  
25 categories of alleged violations in this proceeding that would thereby ensure that the licensed  
26 entity was being treated fairly. (*David Tr. 11540:8-15, 11391:16-11392:24, Vandepas Tr.*  
27 *985:3-13, Roy Tr. 5621:17-5622:16, 5751:20-24, Dixon Tr. 5761:7-11, Masters Tr. 1805:14-24,*  
28 *1806:14-18, Cignarale Tr. 22942:4-12, 22943:15-21)*

- 1 a. CDI has no written standards for its interpretation that CIC § 10133.66(c) requires  
2 insurers to send hard copy letters in response to paper claims (or even more  
3 specifically, paper claims not paid within 15 working days). (*David Tr. 11391:16-*  
4 *11392:24, Vandepas Tr. 985:3-13, Roy Tr. 5621:17-5622:16, Dixon Tr. 5761:7-11*)
- 5 b. CDI has no written standards for its interpretation that CIC § 10169(i) requires  
6 notice of IMR rights to member EOBs, that EOBs are considered “letters of denial”  
7 as that term is used in CIC 10169(i), that an EOB’s “Know Your Rights” page or  
8 anything similar is considered a “copy of the insurer’s procedures for resolving  
9 grievances,” or that even if such notice is required on EOBs, that it would be  
10 required on every EOB issued by PLHIC as opposed to only when a claim has been  
11 “denied, modified, or delayed” (*Roy Tr. 5751:20-24*)
- 12 c. CDI has no written standards for its interpretation that CIC § 10123.13(a) requires  
13 notice of CDI right of review on every EOP issued by PLHIC, as opposed to only  
14 for claims that are “contested or denied.” (*Masters Tr. 1805:14-24, 1806:14-18,*  
15 *Cignarale Tr. 22942:4-12*)
- 16 d. CDI had no written standards supporting a conclusion that the vast majority of  
17 alleged violations in this proceeding constituted violations of CIC § 790.03.  
18 (*David Tr. 11540:8-15, Cignarale Tr. 22943:15-21* )
- 19 e. CDI had no written standards around the manner in which an insurer must run its  
20 operations but nevertheless offered substantial criticism certain aspects of PLHIC’s  
21 operations. (*Exh. 5191; Berkel Tr. 7655:25-7656:26, Laucher Tr. 13250:22-*  
22 *13251:17, 13365:9-24, 13399:20-13404:1, 13070:24-13071:18, Stead Tr. 24333:6-*  
23 *25*)

24 **B. Failure to Follow Standards that CDI Does Employ**

25 230. CDI senior management testified that staff are not even required to follow those  
26 internal CDI rules and guidelines that do exist. (*Smith Tr. 291:10-293:22, 469:7-11, Laucher Tr.*  
27 *13113:25-13116:10, Cignarale, Tr. 23017:22-23018:19, 24106:1-13; see also Exh. 5645, Samer*  
28 *Alami Declaration, 3:18-21*)

1           231. In this case, there have been a number of instances where CDI staff did not follow  
2 established CDI rules and guidelines, which increased the risk of prejudice to PLHIC. (*Dixon*  
3 *Tr. 4694:24-4695:13, 4703:2-4704:7,5201:15-5203:8, Laucher Tr. 13113:25-13115:16, Stead*  
4 *Tr. 24386:2-24388:1, 24734:1-20)*

5                   *Tolerance Thresholds*

6           232. Insurance Code Section 733 requires that CDI observe the guidelines and  
7 procedures in the NAIC Examiner’s Handbook, but CDI has refused to apply the NAIC rules and  
8 guidelines, candidly admitting that “CDI does not, and is not required to, follow the NAIC  
9 Market Regulation Handbook,” including use of tolerance thresholds. (*Exh. 1184, p. 108:16-27;*  
10 *Laucher Tr. 13431:9-13, 14135:13-22, Dixon Tr. 5286:23-5287:13, Cignarale Tr. 22856:16-*  
11 *22858:19)*

12           233. CDI’s contention that the “Examiner’s Handbook” referenced in the statute applies  
13 only to financial examinations is unpersuasive. (*Exh. 5707, p. 2; Stead Tr. 24421:15-24423:10)*

14           234. In particular, at the time the California Legislature passed Section 733, the  
15 Examiner’s Handbook was one book that included guidelines on both financial examinations and  
16 market conduct examinations. (*Exh. 5707, p. 2; Stead Tr. 24421:15-24422:20, Laucher Tr.*  
17 *14132:20-14134:19)*

18           235. As to the appropriate version of the NAIC handbook that should be considered by  
19 the Court, the parties took different positions; Respondent PLHIC contends that the Court should  
20 look at the most current version while CDI asserts that the Court should consult the version in  
21 place at the time of the examination.

22           236. In reviewing the NAIC handbooks in evidence and the testimony of PLHIC’s  
23 regulatory expert Sue Stead, the Court concludes it is appropriate to use the 2011 version of the  
24 NAIC handbook (*Exh. 5648*) to determine whether PLHIC’s performance established a general  
25 business practice with respect to those categories of violations amenable to such an analysis  
26 (*e.g.*, claims payment timeliness, claims acknowledgment and incorrectly paid claims) because  
27 that version of the NAIC handbook reflects the most up-to-date approach by regulators around  
28

1 the country, and reflects what those regulators had been doing for many years prior. (*Stead Tr.*  
2 *25398:4-25401:13, 25401:24-25409:8*)

3 237. In addition, CDI has adopted a number of measures of performance in other cases  
4 that are consistent with the NAIC handbook and contemplate something less than perfect  
5 performance, either through particular percentage metrics for performance or through a standard  
6 of substantial compliance. (*Exh. 5191, Undertaking 19, Exh. 5671, p. 42 (MEGA Settlement*  
7 *citing NAIC handbook), Exh. 5698, p. 6 & REQ. OFF. NOT., Tab 7, pp. 1 & 12 (7% NAIC*  
8 *handbook standard), Exh. 5292, p. 7347-7350 (United MAWG agreement benchmarks), Exh.*  
9 *5670; Farmers Ins. Exchange, UPA 02-02-5694-AP, November 21, 2005 (requiring only*  
10 *“reduction of at least 32.5 % in number of violations issued” by CSB staff the next year))*)

11 238. Indeed, CDI specifically adopted the NAIC thresholds in monitoring compliance in  
12 connection with both the MEGA and Unum settlements. (*Exhs. 5671, p. 42, 5698, p. 6 & REQ.*  
13 *OFF. NOT., Tab 7, pp. 1 & 12; Cignarale Tr. 23795:9-23796:19*) And, after settling with  
14 Unum as part of a multi-state examination, California conducted a separate market conduct  
15 examination of the insurer and applied the NAIC tolerance thresholds in determining not to  
16 impose additional penalties on the company. (*Unum 2008 Public Report, Request for Official*  
17 *Notice, Tab 31*)

18 239. Notably, in 2008, CDI conducted investigations of 23 licensed health insurers but  
19 brought enforcement actions against only four of them, suggesting that CDI tolerates a level of  
20 performance below perfection. (*Exh. 5649, p. 126-127*)

21 240. CDI’s refusal to follow these established guidelines and practices have resulted in  
22 actual prejudice to PLHIC. If CDI applied to PLHIC the tolerance thresholds it is required to  
23 apply, and has applied to other insurers, there would be no dispute that PLHIC’s performance  
24 with respect to the timely payment of claims, acknowledgment of claims, and incorrect payment  
25 of claims would create a presumption that PLHIC did not have a general business practice of  
26 violating those insurance laws. (*Exh. 5712, pp. 37-38; Stead Tr. 24424:19-24435:1*)

27  
28

1           241. CDI’s contention that it has a “zero tolerance” approach to errors and does not look  
2 at compliance in terms of percentages is not credible. (*Stead Tr. 24257:19-24258:5, 24423:23-*  
3 *24424:15*)

4           242. CDI management conceded they have never “seen an error-free system in all [their]  
5 years’ at CDI, (*Cignarale Tr. 23722:15-23724:4*), have never “even evaluated whether it is  
6 possible to have an error-free claims handling process,” (*Cignarale Tr. 23715:2-21, Laucher Tr.*  
7 *14157:12-16*), and its integration expert agreed he was not “holding PLHIC or United to a  
8 standard of perfection,” because doing so “wouldn’t be fair.” (*Boeving Tr. 19406:5-10; see also*  
9 *Kessler Tr. 20866:6-22*)

10                   *Destruction of Documents*

11           243. CDI destroyed documents related to this proceeding despite the existence of  
12 internal rules that mandate preservation of relevant information. (*CIC Section 12921.1(a)(4);*  
13 *Laucher Tr. 13114:15-22, 13169:9-24, 13105:21-13106:18, Dixon Tr. 4661:2-4663:7, 4667:16-*  
14 *20, Tiffany Tr. 8664:4-21, Roy Tr. 5632:2-5, Smith Tr. 291:10-292:10, 293:1-294:5, 295:24-*  
15 *296:11; Exhs. 5407 (p. 6997-98), 5411 (p. 7054), 5085, 5368*)

16           244. CDI witnesses admitted that they did not comply with CDI’s own procedures for  
17 retaining relevant documents: “I purged many documents.” (*Smith Tr. 469:11*); “I would have  
18 destroyed many emails, yes . . .” (*Laucher Tr. 13114:6-12*); “I likely would have deleted e-mail  
19 related to this examination.” (*Laucher Tr. 13106:2-3; see also Smith Tr. 291:19-22, 297:15-*  
20 *298:10, Love Tr. 15758:24-15759:2, Laucher Tr. 13114:4-13116:10, 13118:19-13119:1; Exh.*  
21 *5368*)

22           245. CDI witnesses who destroyed documents, such as Nicoleta Smith, admitted that at  
23 “the time [she] purged [her] files initially, [and] didn’t take any affirmative steps at that time to  
24 see if there were, in fact, duplicates” before destroying them. (*Smith Tr. 466:19-467:19; see also*  
25 *Smith Tr. 293:20-22, Laucher Tr. 13115:4-13116:6*)

26           246. Files were also purged without regard to what was contained there. (*Exhs. 5645 -*  
27 *hard drives “completely wipe[d],” 5412, 5413, 904 (Ms. Rosen’s hard drive not copied or saved*  
28 *when her computer was replaced); Smith Tr. 296:12-298:7, Cignarale Tr. 24095:4-7 (“[T]he*

1 *first day of trial, Ms. Smith’s computer was wiped clean and used for some other purpose”),*  
2 *24095:20-23 (“[w]ith respect to the Smith computer, the computer was taken as a part of a*  
3 *department-wide or unit-wide recycling, and data was lost “))*

4 247. Independent forensic examiner Samer Alami offered an undisputed declaration that  
5 while CDI staff “ha[d] the ability to archive old emails,” CDI’s IT personnel told him that CDI  
6 “users do not take this step and they simply erase their old emails.” (*Exh. 5645, ¶ 8*)

7 248. Mr. Alami also concluded that CDI’s email backup was limited to a 90-day  
8 window for “disaster recovery purposes,” and that “no litigation and/or legal hold [was] put in  
9 place for the PacifiCare matter . . . .” As a result, data destroyed by Ms. Smith was  
10 unrecoverable. (*Exh. 5645, ¶¶ 8-14*)

11 249. Although the exact impact of CDI’s destruction of documents cannot be assessed, it  
12 is clear that many relevant documents were destroyed. (*Smith Tr. 291:10-292:10, Laucher Tr.*  
13 *13105:21-13106:18, 13113:17-13114:14, 13118:19-19119:1, Love Tr. 15758:24-15759:18*)

14 250. Indeed, CMA documents that CDI destroyed but PLHIC later obtained via  
15 subpoena from CMA turned out to be highly relevant and potentially exculpatory. (*See, e.g.,*  
16 *Exhs. 5412-5415*)

17 *Internal Guidelines Governing Acceptance of Provider Complaints*

18 251. CDI failed to follow its internal guidelines with regard to receiving provider  
19 complaints or handling inquiries from providers. For example, CDI waived its written guidelines  
20 requiring providers to first exhaust their provider dispute resolution appeals with the insurer  
21 before submitting inquiries to CDI for CMA-related and “special” complainants. *See also*  
22 *Findings 267-274; [re: process for receiving complaints - Exhs. 5412, 5413; Laucher Tr.*  
23 *13191:9-13195:9, Kessler Tr. 21136:5-18; re: VIP complainants - Exhs. 5027, 5028, 5029,*  
24 *5196, 5438, 5687, 5688; Smith Tr. 311:10-312:19, Diaz Tr. 13469: 22-13471:10, 13472:25-*  
25 *13473:12, Stead Tr. 24742:5-25]*

26 **C. Material Changes in Position**

27 252. CDI appears to have changed or contradicted its prior positions on key issues in  
28 this proceeding that materially impact the right, if any, of CDI to assess a penalty against PLHIC

1 for the charged violations. (*Stead Tr.* 24326:23-24333:25, 24340:11-24341:2, 24348:1-24350:4,  
2 24356:6-24357:20, 24342:24-24345:6, 24401:17-24403:5; *Exhs.* 5707 (p. 4-5, Sections C & D),  
3 5708 (pp. 15-17 & 19), 5712 (p. 28-29))

4 253. CDI's change in position on these key issues appears arbitrary and not in the public  
5 interest.

6 254. CDI has changed its position as to what conduct examined in the 2007 MCE  
7 constitutes a Section 790.03 violation, expanding its initial statutorily-required identification of  
8 90 violations to over 900,000 based on the same set of facts more than two years later. [See](#)  
9 [Findings 325-332](#).

10 255. CDI has also materially changed its position in terms of what constitutes an  
11 acceptable level of timely claims processing, such as Deputy Commissioner Cignarale's  
12 contention that "PacifiCare complied with the metric at least around timeliness [in [Ex. 5191](#)],"  
13 but could still be subject "to a determination that they have engaged in an unfair business  
14 practice." (*Cignarale Tr.* 23437-38)

15 256. CDI presented no plausible explanation for how an objective standard of timeliness  
16 CDI imposed on PLHIC as a condition for approving the Merger could subsequently constitute  
17 an unfair business practice.

18 257. Under the circumstances, it is only fair to hold PLHIC to the standard of timeliness  
19 set forth in the Undertakings, and that compliance with that standard precludes assessment of any  
20 penalty for conduct governed by, and in compliance with, the Undertakings. (*Kessler Tr.*  
21 [20900:14-20901:19](#); *Stead Tr.* 25993:18-25994:20, 26000:8-14, 26013:22-26015:21 (CDI  
22 *agreed to Undertaking 19 claim payment timeliness metrics and "compliance with that standard*  
23 *is being treated as an unfair practice, and the company is being cited for exactly what that*  
24 *standard said that they should be doing"*))

25 258. In this proceeding, CDI has imposed its subjective judgments upon the manner in  
26 which PLHIC runs its operations even though historically, it had little interest in getting involved  
27 in the details of PLHIC's operations. (*Monk Tr.* 8833:8-8834:18, *Stead Tr.* 24333:6-25)

28

1           259. CDI also did not offer any input or criticisms on operational matters in connection  
2 with the remedial efforts PLHIC has undertaken. (*Berkel Tr. 7655:25-7656:24* (“*But we never*  
3 *had any satisfactory conversation about whether or not the items that we proposed, if they were -*  
4 *- if they met the Department’s needs*” . . . “[*s]o as far as I know that there wasn’t really any*  
5 *interest in confirming that we were doing what we said we were doing.*”))

6           260. The Undertakings impose no standards with respect to staffing, nor did CDI impose  
7 such standards in connection with PLHIC’s remedial efforts. (*Exh. 5191* (*Undertakings contain*  
8 *no commitments relating to staffing or the specific manner in which PLHIC would run its*  
9 *operations*); *Berkel Tr. 7655:25-7656:24, Laucher Tr. 13250:22-13251:17, 13365:9-24,*  
10 *13399:20-13404:1, 13070:24-13072:8*)

11           261. Similarly, CDI has not published or cited to any standards relating to the staffing or  
12 the manner in which an insurer must run its operations that would apply to the circumstances  
13 here.

14           262. In the absence of any such objective standards, the Court is not inclined to impose  
15 its opinions or those of the agency to PLHIC’s operations.

16           **D. Public Statements of CDI Concerning PLHIC**

17           263. In early 2008, then-Commissioner Poizner made public statements that  
18 demonstrated an unacceptable lack of objectivity. Those statements described a “claims  
19 meltdown” at PLHIC that “PacifiCare simply can not or will not fix.” Those statements,  
20 however, were not consistent with CDI’s own internal reports or PLHIC’s behavior from the  
21 time of the Merger through the date of Commissioner Poizner’s comments (*see Findings 13, 14;*  
22 *299-321*). (*Exh. 5272; see also Exh. 1*)

23           264. Deputy Commissioner Cignarale agreed that he did not “consider the statements  
24 that were attributed to Commissioner Poizner to reflect the objectivity that is required of the  
25 Department of [I]nsurance.” (*Cignarale Tr. 23455:8-20*)

26           265. It is not credible to think that the Commissioner’s staff would act inconsistently  
27 with the Commissioner’s very public views of the Company. (*Stead Tr. 24390:18-24391:11*  
28

1 (“[I]t wouldn’t surprise me that staff would act in accordance with public statements or  
2 direction from the Commissioner. In fact, the Commissioner would expect it.”))

3 266. CDI continued to demonstrate a lack of objectivity when its official spokesperson  
4 publicly described a “horrible” situation for providers and policyholders that did not comport  
5 with CDI’s own internal reporting or CDI’s obligation to remain objective and fair. (*Exh. 5391*)

6 **E. Significant Influence of Providers**

7 267. The absence of standards and a clearly defined process created an opportunity for  
8 irregularities to occur, as outlined below, that adversely affected PLHIC during the course of the  
9 CDI’s investigation, examination and enforcement action.

10 268. Ms. Stead’s opinion was persuasive that CDI’s conduct, as outlined in [Findings](#)  
11 [224-283](#) was unusual, irregular and inconsistent with how an objective regulator would act with  
12 respect to an insurer. (*Stead Tr. 24375:5-24385:22, 24387:9-24396:8, 24525:3-19; Exh. 5707,*  
13 *pp. 6-7*)

14 269. During its investigation of PLHIC, CDI staff identified certain complaining  
15 providers as “special complainants” and “VIP complainants” that required weekly updates to the  
16 Commissioner even though these complainants were outside CDI’s jurisdiction or their issues  
17 had already been addressed, causing one staff member to complain that CDI staff had gone “way  
18 above and beyond normal procedures in providing service.” (*Exhs. 5026, 5027, 5028, 5029,*  
19 *5197, 5198, 5707, p. 3, 5683, 5684, 5689; Smith Tr. 322:15-22, Kessler Tr. 20980:13-22*)

20 270. CDI witnesses uniformly evidenced a lack of knowledge or inability to recall, even  
21 generally, why certain providers were identified as “special” or “VIP” complainants or why it  
22 was necessary or appropriate to identify them as such, or to waive established procedures for  
23 them vis-à-vis PLHIC. (*Cignarale Tr. 24031:21-24033:16, Masters Tr. 571:3-572:7, Roy Tr.*  
24 *5732:6-5733:1*)

25 271. As to CMA, CDI counsel Andrea Rosen actually acknowledged that “as a result of  
26 [CMA’s] teachings and influence, [she had] gotten the CDI to expand their scope” of the  
27 examination of PacifiCare to areas never “previously examined.” (*Exh. 5414*)

28

1           272. CMA never met with the staff actually charged with receiving complaints, but  
2 limited their communications to executive officers, such as Deputy Commissioner David Link  
3 and Commissioner Poizner, as well as Ms. Rosen. (*Wetzel Tr. 16790:3-8, 16842:17-16843:21,*  
4 *16866:12-16868:4, 16870:3-16871:19*)

5           273. CDI accepted as true CMA’s unsubstantiated reports of exaggerated numbers of  
6 provider complaints concerning PacifiCare as well as other CMA misstatements made in  
7 connection with the PacifiCare investigation. (*Kessler Tr. 20965:18-20967:8, Wetzel Tr.*  
8 *16810:6-18*)

- 9           a. The CMA misrepresented that it had received thousands of complaints from  
10 PacifiCare providers when in fact it received a total of 237 inquiries about  
11 PacifiCare from March 2005 to June 2009, and of those 237 inquiries, only 25  
12 percent of those related to complaints about contracts and claims processing.  
13 (*Kessler Tr. 20967:9-20969:7, Berkel Tr. 7377:17-7378:12, McFann Tr. 10724:7-*  
14 *10725:14; Exhs. 5253, 5254*)
- 15           b. PacifiCare demanded, but never received, documentation supporting CMA’s claim  
16 of “thousands of complaints.” (*McFann Tr. 10724:18-10725:14*)
- 17           c. CMA misrepresented in its original complaint letter dated February 16, 2007 that  
18 no process existed to escalate complaints to PacifiCare when in fact PacifiCare had  
19 established such a process in November 2006 and CMA has conceded that the  
20 process “addressed any concerns that were raised by [CMA].” (*Wetzel Tr.*  
21 *16827:24-16828:14, 16646:15-21, Black Tr. 1340:3-10*)
- 22           d. CMA also made it appear, at the time of its February 2007 complaint, that its  
23 members were facing unresolved issues when in fact all but two of the issues  
24 identified in the letter had been resolved and the two remaining issues were in the  
25 process of being resolved. By the time CMA formally requested that CDI conduct  
26 an investigation of PacifiCare, PacifiCare had resolved all of CMA’s pending  
27 issues. (*Black Tr. 1349:18-1350:21, McFann Tr. 10726:17-25*)
- 28

- 1 e. In fact, PacifiCare and CMA had resolved the vast majority of issues between them  
2 by the end of 2007, resulting in just two complaints in the three years from 2007-  
3 2010. (*Black Tr. 1340:3-10; Exhs. 5503, 5504*)  
4 f. Finally, CMA attributed the problems in its February 2007 letter to “widespread  
5 misconduct” when just four weeks prior it had attributed the problem to a lack of  
6 administrative capacity. (*Black Tr. 1344:11-1346:24*)  
7 g. Indeed, CMA has a history of accusing PacifiCare of misconduct in the absence of  
8 supporting evidence. (*Black Tr. 1347:5-1349:10; Exhs. 5083, 5084*)

9 274. Rather than investigating CMA’s assertions more carefully, CDI staff encouraged  
10 CMA members to make more complaints to CDI on the theory that the more complaints “racked  
11 up” the better, and assured CMA that it “will be pleased with the direction [CDI is] heading.”  
12 (*Exh. 5413; Kessler Tr. 20975:16-20976:21*)

13 275. While the number of complaints received by CDI increased after this email (*Exh.*  
14 *5413*), CDI staff ultimately classified the vast majority of them as unjustified. (*Exh. 5622, p. 39;*  
15 *Kessler Tr. 20979:7-20980:12*)

16 276. Nevertheless, the number of complaints served as the “main cause” for bringing  
17 this enforcement action. (*Exh. 1184, p. 7:1-13; Laucher Tr. 13194:24-13195:9*)

18 277. During this period CDI staff also waived for CMA members established procedural  
19 rules for dealing with provider complaints, which inflated the number of complaints that CDI  
20 accepted for review. (*Exh. 541; Wetzel Tr. 16832:1-16833:11, 16838:23-16840:21, 17196:4-*  
21 *Ex. 5412**20, Kessler Tr. 20977:13-20978:1*)

22 278. CDI also reopened closed complaint files in direct response to provider pressure.

- 23 a. One example of CDI reopening a previously closed complaint in response to  
24 outside pressure involved testifying witnesses Dr. and Mrs. Griffin. On February  
25 21, 2007, CDI staff had closed the Griffin complaint file and sent the Griffins a  
26 letter explaining that because “your complaint indicate[s] that there is a difference  
27 of opinion between you and the insurance company that this Department, as  
28

- 1 outlined in California Insurance code [sic] [Section 12921.4\(a\)](#), does not have the  
2 authority to decide.” (*Exh. 5651*)
- 3 b. Despite the closing of the Griffin complaint, CDI management elected to reopen  
4 the matter after a legislator sent CDI an inquiry about the Griffin complaint and  
5 CDI elected to designate the Griffins as “special complainants” requiring weekly  
6 reports to the Commissioner on the status of their complaint. (*Exhs. 5027, 5687,*  
7 *5688; Roy Tr. 5730:15-20, Smith Tr. 322:15-22*)
- 8 c. For the first time ever, on March 29,2007, CDI cited PLHIC in connection with the  
9 Griffin complaint for failing to include IMR language on an EOB even though the  
10 complaint involved a paid claim and did not implicate a potential right to an IMR.  
11 (*Exh. 37; Cignarale Tr. 24042:23-24044:5*)
- 12 279. CDI staff also became involved on behalf of providers in efforts to change the  
13 terms of provider contracts with United and PacifiCare.
- 14 a. CDI discussed issues with CMA involving PacifiCare and United provider contract  
15 terms and pricing, which is not within CDI’s jurisdiction. (*Berkel Tr. 7566:12-*  
16 *7567:15, Wetzel Tr. 16814:23-16816:13, 17194:13-17195:9*)
- 17 b. A CMA witness admitted that CMA seeks to “actually change the terms of the  
18 contracts that these health insurance companies are [entering into with] providers.”  
19 (*Black Tr. 1334:17-21*)
- 20 c. CDI complained to PacifiCare about its “unfair” contract terms for providers even  
21 though it had no basis or jurisdiction to make such complaints. (*Berkel Tr.*  
22 *7566:12-7567:15, Laucher Tr. 13206:4-18*)
- 23 280. Contract terms also became a subject of discussion with the University of  
24 California health systems when CDI staff met with UC representatives just one month prior to  
25 the expiration of UCSF’s contract with PacifiCare. (*Martin Tr. 4190:10-4193:11; Exh. 5155*)
- 26 a. CDI staff met with the UC lawyer negotiating rates with PacifiCare on behalf of the  
27 UCs and that lawyer served as the principal contact with CDI. (*Wetzel Tr.*  
28 *16847:11-16848:7*)

- 1           b. UC representatives filed a written complaint against PacifiCare with CDI just  
2           weeks later even though a UC executive admitted that UCSF “hadn’t even  
3           discovered any issues with PacifiCare at the time [that] letter was sent.” (*Martin*  
4           *Tr. 4191:2-4194:6; Exh. 5155*)
- 5           c. Shortly after sending its complaint letter to CDI, UCSF extracted a record 30%  
6           increase in rates PacifiCare agreed to pay under its contract with UCSF, and a UC  
7           executive admitted the UCs had “bargaining power” in those negotiations. (*Martin*  
8           *Tr. 4181:2-4182:17, 4190:10-4191:18; Exh. 5145; Kessler Tr. 20986:17-*  
9           *20988:21, 21248:14-21249:4; Exh. 5153*)

10           281. In October 2007, CMA executives expressed their dissatisfaction with the status of  
11           the examination against PacifiCare (to the Deputy Commissioner of Legislative Affairs) and  
12           provided a “wish list” of actions including the filing of an enforcement action and assessment of  
13           penalties. (*Exh. 5415; Wetzel Tr. 16672:4-10*)

14           282. Weeks later, CDI issued the draft 2007 MCE report against PacifiCare citing over 1  
15           million violations. (*Exh. 116*)

16           283. CDI continued to work with CMA representatives throughout this litigation,  
17           receiving praise from CMA about the “gold mine” of additional violations pleaded during the  
18           enforcement proceeding, and at another point assisting CMA in “preparing a feature about the  
19           PacifiCare prosecution.” (*Exhs. 964, 5497, 5498, 5512*)

20           284. That feature misrepresented that “PacifiCare refused to settle and the DOI has been  
21           forced to take formal administrative action and seek the full extent of punishment allowable  
22           under the Insurance Code.” (*Exh. 5497; Cignarale Tr. 23088:23-23090:7*)

23           285. Dr. Kessler’s opinion was persuasive that a lengthy enforcement proceeding  
24           principally serves provider interests by potentially weakening PacifiCare’s and United’s  
25           bargaining power in contracting negotiations with providers. (*Kessler Tr. 20983:9-20984:4*)

1                    Provider Witnesses

2                    286. The only provider witnesses CDI offered at trial – Dr. and Mrs. Griffin and Dr.  
3 Mazer -- had close connections to CMA. (*Griffin Tr. 2679:12-2681:9, 2745:14-19, Mazer Tr.*  
4 *3022:6-19, 3047:4-14, 3091:18-25*)

5                    287. In fact, CMA specifically solicited the Griffins to testify against PacifiCare in this  
6 enforcement action (*Wetzel Tr. 16768:3-16769:5, 16770:10-16771:9, 16773:7-13; Exh. 5505*),  
7 and Dr. Mazer is a member of CMA’s board and “intimately involved” with CMA. (*Mazer Tr.*  
8 *3022:6-19, 3047:4-14, 3091:18-25*)

9                    288. None of these witnesses’ testimony supported a conclusion that PLHIC engaged in  
10 unfair business practices.

11                    The Griffins

12                    289. While Dr. Griffin and Kim Griffin testified that PLHIC failed to pay three claims at  
13 the correct rate of reimbursement, in reality, PLHIC had reprocessed the claims and paid interest  
14 within the standard appeals process. (*Griffin Tr. 2718:1-2729:22*)

15                    290. Though the Griffins contended that the claims were still not paid correctly, the  
16 Griffins failed to provide CDI with basic information concerning their various complaints. (*Exh.*  
17 *5121*)

18                    291. Several months after filing their complaint, the Griffins dropped the matter and  
19 never pursued it further. (*Griffin Tr. 2763:22-2764:2*)

20                    292. The only evidence produced at trial to support their allegations regarding claims  
21 payment issues was an unsigned fee schedule with handwritten portions that was neither part of,  
22 nor reflected in, Dr. Griffin’s contract with PacifiCare. (*Exh. 294; Griffin Tr. 2738:14-2740:3*)

23                    293. Ms. Griffin admitted, moreover, at trial that her complaint to the San Francisco  
24 Business Times that PacifiCare “was paying 40 percent less than contracted rates was not a true  
25 statement.” (*Exh. 5123; Griffin Tr. 2765:20-2766:13*)

26                    294. As to the contention that PacifiCare had improperly removed Dr. Griffin from  
27 provider directories, the Griffins produced no evidence to support their contention. To the  
28 contrary, Ms. Griffin confirmed that her husband correctly appeared in all of the relevant

1 directories over a four year period of time after being presented with hard copies of those  
2 directories. (*Exhs. 5124, 5125, 5126, 5127; Griffin Tr. 2787:14-17*)

3 *Dr. Mazer*

4 295. Though Dr. Mazer, like the Griffins, claimed to have been underpaid, he did not  
5 present the purported contract or any other evidence to support his claim. (*Mazer Tr. 3058:12-*  
6 *15, 3071:15-3076:17*)

7 296. Dr. Mazer's disputes with PacifiCare involved a contractual dispute that is outside  
8 CDI's authority to resolve. (*Mazer Tr. 3082:19-23, 3087:5-3088:8; Exhs. 5121, 5651*)

9 297. While Dr. Mazer complained at length in his direct testimony about how bad  
10 PacifiCare treated him post-Merger, he had complaints about only two claims out of 65 that were  
11 processed through PacifiCare's PPO program. (*Exh. 5134*)

12 298. With respect to those two claims, one was submitted to PacifiCare PPO in  
13 November 2008, and the other in December 2008, and both were paid in January 2009, with  
14 interest where appropriate. (*Exh. 330; Mazer Tr. 3089:9-3091:8*)

15 **IV. CDI'S ENFORCEMENT ACTION IGNORES PLHIC'S REMEDIATION,**  
16 **COOPERATION AND THE LACK OF HARM**

17 **A. Absence of Prior Enforcement History**

18 299. PLHIC has not previously been the subject of an enforcement action by CDI, nor  
19 has PLHIC previously been cited for the conduct at issue. (*Exh. 1184, p. 7:26-8:2*)

20 **B. Absence of Significant Harm**

21 300. According to CDI, the dollars recovered under the 2007 MCE totaled \$156,455.  
22 (*Exh. 1*)

23 301. Prior to notice of the 2007 MCE, PLHIC paid a total of \$765,157 to correct  
24 problems associated with the incorrect pre-ex exclusionary period.

25 302. Prior to the 2007 MCE, PLHIC paid an additional \$89,191 to re-work claims  
26 associated with contracts loaded after their effective date.

27 303. CDI failed to demonstrate any further quantifiable harm associated with the  
28 charged violations in the case.

1           304. CDI could not identify a single member whose medical condition suffered as a  
2 result of the charged violations in this case.

3           305. CDI could not identify a single member or provider who failed to take some action  
4 as a result of language omitted from form EOPs and EOPs.

5           306. CDI attempted to locate members and providers who could testify about any harm  
6 that resulted from the alleged violations (*Exhs. 5273, 5413*), but after twenty-seven months of  
7 hearing, CDI presented limited testimony (*i.e.*, the Griffins, Dr. Mazer, Mrs. W and Mr. R) that  
8 did not support a finding of quantifiable harm beyond the dollars identified above in [Findings](#)  
9 [300](#) and [303](#).

10           307. In connection with offering his penalty recommendation, Deputy Commissioner  
11 Cignarale admitted that he could not quantify the “tangible harm” resulting from any of the  
12 alleged violations aside from what was contained in the factual assumptions provided to him by  
13 CDI counsel, which he made no effort to independently verify. (*Cignarale Tr. 23232:3-7,*  
14 [23481:11-14](#))

15           308. Although CDI, through Mr. Cignarale, contends that the alleged violations also  
16 resulted in non-monetary, non-tangible harm (such as emotional distress and frustration), CDI  
17 counsel admits that such alleged harm is speculative. (*Cignarale Tr. 23340:22-23341:13*) When  
18 PLHIC counsel asked Mr. Cignarale to assess the harm when Blue Cross’s conduct caused Mrs.  
19 W’s son to be denied medical care, CDI counsel objected that the question called for speculation  
20 and that Mr. Cignarale had no foundation to offer such an opinion. (*Id.*)

21           309. The harm in the other enforcement actions brought at the time substantially  
22 exceeded the harm here. (*See Findings re Historical Penalties; Exh. 5708, pp. 12-13; Stead Tr.*  
23 [24311:2-24320:13, 24321:14-24327:22](#))

24           **C. Remediation**

25           310. PLHIC remediated all issues related to the charged violations “well before this  
26 administrative hearing began.” (*Cignarale Tr. 23470:21-23471:5; see also Exhs. 736, 750,*  
27 [5707, 5015, 5016, 5165, 5264; Stead Tr. 24458:4-18, Berkel Tr. 7562:25-7563:11, 7745:9-](#)  
28

1 7749:20, 7755:24-7757:3, 7767:6-7768:8, 7769:14-7771:7, 7477:24-7478:8, 7480:7-20,  
2 *Vonderhaar Tr. 6964:8-6965:19*)

3 311. PLHIC also remediated issues with its core constituencies, including providers. In  
4 November 2006, PLHIC established a process to escalate complaints by CMA members if  
5 necessary and CMA conceded that the process “addressed any concerns that were raised.”  
6 (*Wetzel Tr. 16827:24-16828:14, 16646:2-21, Black Tr. 1340:3-10, McFann Tr. 10717:10-*  
7 *10718:7*)

8 312. PLHIC and CMA had resolved the vast majority of issues between them by the end  
9 of 2007, resulting in just two complaints in the three years from 2007 to 2010. (*Black Tr.*  
10 *1340:3-10, McFann Tr. 12967:15-12968:16, 10717:10-10718:7, Lewan Tr. 11671:17-24,*  
11 *Berkel Tr. 10214:16-20; Exhs. 5353, 5503, 5504*)

12 313. In a 2010 “Physicians Advocate Survey,” physicians selected PacifiCare as the  
13 “plan providing the best level of service” by a write-in vote. (*Harvey Tr. 11792:20-11794:6*)

#### 14 **D. Cooperation**

15 314. PLHIC remained cooperative before, during and after the 2007 MCE. (*David Tr.*  
16 *11595:7-11596:6, Dixon Tr. 4717:6-13, Roy Tr. 5600:15-19, Stead Tr. 24469:19-24, 24983:5-*  
17 *14; Exh. 5184, p. 6298*)

18 315. PLHIC self-disclosed a number of issues to CDI. [See Findings 195, 196.](#)

19 316. PLHIC turned over to CDI massive volumes of information and data. [See Finding](#)  
20 [196.](#)

21 317. PLHIC agreed to remediate issues of concern to CDI and did not condition its  
22 corrective action on resolution of any enforcement action against it as other insurers have done.  
23 [See Findings 197, 310-312.](#)

24 318. While CDI suggests that PLHIC was not cooperative during the 2007 MCE,  
25 internal CDI staff communications described a significant level of cooperation by PLHIC,  
26 referring to PLHIC employees as acting on their “best behavior,” as being “very  
27 accommodating,” and, if anything, being too eager to please. (*Exhs. 5030, 5031, 5310; Masters*  
28 *Tr. 490:25-491:10, 492:11-493:6*)

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319. Supervising Compliance Officer Towanda David thanked PLHIC for “[its] cooperation during the examination process” in CDI’s draft report to PLHIC. (*Exh. 5184, p. 6298*)

320. Consistent with that conclusion, the DMHC, as part of its joint investigation of the Company, made an express finding in January 2008 that “at all times . . . PacifiCare worked collaboratively with the DMHC to resolve all issues that were identified.” (*Exh. 5290 at Exh. E, p. 4653*)

321. With regard to the Undertakings, CDI’s outside auditor Marsh concluded that “UnitedHealth and PacifiCare [] made a good faith effort to comply with the Undertakings.” (*Exhs. 5548, 5321; Monk Tr. 8924:7-23, 18065:5-18069:5*)

**E. Lack of Notice**

322. PLHIC acted in good faith in interpreting the laws at issue in this case. There is no evidence to suggest that PLHIC knew that it was violating the law.

323. CDI has articulated for the very first time novel interpretations of key statutes and regulations underlying the Principal Alleged Violations. These include:

- a. CDI’s assertion that [CIC § 10133.66\(c\)](#) requires PLHIC to send written acknowledgment letters upon receipt of paper claims.
- b. CDI’s assertion that [CIC § 10169\(i\)](#) requires PLHIC to give notice of the right to request an Independent Medical Review (“IMR”) on EOBs.
- c. CDI’s assertion that a “contested or denied claim, for purposes of [CIC Section 10123.13\(a\)](#)’s notice requirement, is any claim for which the insurer pays less than the billed charges, even if paid at the contracted rate that the provider expects to be paid.
- d. CDI’s assertion that insurers must meet a standard of perfection with respect to claims payment timeliness, and that performance meeting or exceeding the tolerance thresholds in Undertaking 19 and the NAIC guidelines is still an unfair business practice under [CIC Section 790.03](#).

1 e. CDI's assertion that the Principal Alleged Violations are also violations of [CIC](#)  
2 [Section 790.03](#).

3 324. PLHIC did not, and could not have had, notice of CDI's interpretations of statutes  
4 and regulations underlying the Principal Alleged Violations because CDI did not put PLHIC or  
5 the industry on notice of its interpretations.

6 **V. CDI CANNOT DRAMATICALLY ALTER ITS THEORY LATE IN THE**  
7 **CASE**

8 325. The law required CDI to report any violations of Section 790.03 in the Public  
9 Report of the 2007 MCE, and CDI reported only 90 alleged violations in the Public Report.  
10 ([CIC Section 12938\(b\)](#); [Exh. 116, p. 1289](#))

11 326. CDI staff reported in writing and testified at trial that, at the time CDI issued its  
12 Public Report, they believed that for many of the violations at issue in this case, including the  
13 Principal Alleged Violations, were "something other than violations of Section 790.03." ([Exh.](#)  
14 [116, p. 1289](#); [Laucher Tr. 132384:12-13285:7](#) ("Q. When you say you hadn't identified the  
15 790.03 violations, you mean you hadn't identified the failure to pay within 30 working days as a  
16 790.03 violation at the time the [final 2007 MCE] report was prepared? A. Yes."); [David Tr.](#)  
17 [11583:22-11584:5](#) ("Q. So at the time you prepared the Report you did not view them to be  
18 violations of 790.03? . . . The Court: It seems to me that the answer needs to logically be yes.  
19 But I haven't heard an answer, so I am going to allow the question. [Ms. David]: Correct.))

20 327. On May 19, 2010, less than three weeks before the Republican gubernatorial  
21 primary in which then-Commissioner Steve Poizner was a candidate and more than two years  
22 after service of the OSC, CDI materially changed its position on what constitutes a violation of  
23 790.03 and for the first time contended in its Second Supplemental Accusation that the Principal  
24 Alleged Violations (defined in [Finding 219](#)) were violations of Section 790.03. ([Exhs. 1 and 116](#)  
25 [\(identifying only 90 alleged violations of 790.03 as of January 28, 2009\)](#); [Exh. 597](#) [\(asserting](#)  
26 [more than two years after initial OSC was filed that violations previously identified as](#)  
27 ["something other than violations of Section 790.03," were now considered by CDI to be Section](#)  
28 [790.03 violations\)](#)))

1           328. In the Second Supplemental Accusation, filed, CDI also broke with its historical  
2 approach and alleged over 850,000 additional violations by counting every allegedly non-  
3 compliant form EOB and EOP as a separate violation. (*Exh. 597, p. 1-2*)

4           329. CDI had opportunities to change its position regarding Section 790.03 violations  
5 before the 2007 MCE Public Report became final, but chose not to do so. (*Cignarale Tr.*  
6 *23011:1-7, 23013:25-23014:23, 23020:23-23021:23, 23025:12-23028:18*)

7           330. CDI later sought leave to amend the Public Report during the course of this hearing  
8 (on December 15, 2009) to include only two additional alleged violations of Section 790.03, for  
9 a total of ninety-two (92) alleged violations of Section 790.03. (*Exh. 123*)

10           331. While CDI may have changed its policy on what constitutes a violation of Section  
11 790.03, it cannot retroactively apply that new policy to this case. (*Laucher Tr. 14108:16-*  
12 *14112:18, Cignarale Tr. 22784:12-22785:19*)

13           332. Under these circumstances, the Court is persuaded by the opinions of PLHIC's  
14 regulatory expert Sue Stead that CDI's attempt to re-define the violations it contends fall under  
15 790.03 is "arbitrary" and contrary to normal regulatory practices and allowing CDI to change its  
16 position in order to influence of the outcome of this proceeding is inappropriate. (*Stead Tr.*  
17 *26028:19-26029:7*)

## 18       **VI. WIN AT ALL COSTS MENTALITY**

19           333. CDI's conduct indicates that it has adopted a "win at all costs" approach to this  
20 enforcement proceeding.

### 21       **A. Exam and Process Designed to Maximize Number of Violations**

22           334. In the context of the examination, CDI essentially assured that it would find an  
23 unprecedented number of alleged violations by comparing the *number* of alleged violations  
24 resulting from an analysis of PLHIC's entire paid claims population with the *number* of alleged  
25 violations resulting from analyses of much smaller samples of other insurers' claims populations.  
26 (*Dixon Tr. 5156:20-5157:22; Exh. 5418; Kessler Tr. 20921:24-20922:15, Stead Tr. 24369:10-*  
27 *25*).

1           335. Given that CDI used a different method of calculating alleged violations with  
2 PLHIC than with other insurers, it is inappropriate to compare the number of alleged violations  
3 cited against PLHIC against those cited in samples for other insurers. Had CDI examined the  
4 *percentage* of alleged violations in the claims populations of those other insurers, the analysis  
5 would have shown that the number of PLHIC’s alleged violations was no more numerous, and in  
6 many instances, far less frequent, than the number of violations committed by other insurers  
7 according to data that is published by CDI on its website pursuant to [CIC § 12938](#) and is readily  
8 available to its market conduct examination staff.

9           336. CDI also established a review period that it knew would generate alleged  
10 violations, rather than selecting a later period to evaluate whether the issues had been corrected.  
11 [\(Stead Tr. 25945:22-48:23\)](#)

12           337. CDI did not provide an explanation for why it chose to conduct an electronic  
13 examination of all paid claims in the PLHIC matter or why CDI thought it fair to compare those  
14 results to the samples drawn in the other examinations. [\(Exhs. 1, 118\)](#)

15           338. In the Second Supplemental Accusation, filed less than three weeks before the  
16 Republican gubernatorial primary involving then-Commissioner Poizner, CDI broke with its  
17 historical approach and added over 850,000 alleged violations by counting every allegedly non-  
18 compliant form EOB and EOP as a separate violation. [\(Exh. 597, p. 1-2; Stead Tr. 25960:7-12](#)  
19 [\(finding such conduct to be “very unusual”\)\)](#)

20           **B. Misrepresenting Facts to Further Its Goals In this Litigation**

21           339. On multiple occasions, CDI has taken particular positions and interpretations in  
22 order to further CDI’s litigation interests even when those positions were not true, or inconsistent  
23 with CDI’s prior positions on the matter.

24           340. During the course of the hearing, CDI repeatedly represented that “we have made  
25 the complete production, we’re done,” when PLHIC complained that communications between  
26 CDI (including Andrea Rosen) and CMA and other provider interests were missing from the  
27 production. [\(Exh. 5441; Strumwasser Tr. 6436:7-18, 6440:14-15, 6443:16-21, Gee Tr. 6488:18-](#)  
28 [25 \(“\[W\]e did a sweep of everybody’s files once before. We went back to Ms. Rosen’s and found](#)

1 *a couple documents. And she, you know, she is the most likely person to have documents. She's*  
2 *the one who was communicating with them largely. And we've asked her if other people would*  
3 *have documents relevant to the, you know, that's -- and she is the person." ))*

4 341. CDI failed to acknowledge that such documents had existed, or that CDI had  
5 destroyed all such documents in its possession, until PLHIC discovered their existence pursuant  
6 to a subpoena served on CMA. (*Exh. 5441 (describing history of CDI's representations*  
7 *regarding CMA communications); Velkei Tr. 13191:2-8, 13203:1-13205:17; see, e.g., Exhs.*  
8 *5412 through 5415, produced by CMA, but not CDI)*

9 342. While CDI later asserted that the documents were inadvertently destroyed, it did  
10 not explain why CDI failed to disclose their existence in the first instance. (*Exh. 5441*)

11 343. In another example, when CDI first sought to strike Ms. Rosen's name from  
12 PLHIC's witness list, CDI offered the sworn declaration of Ms. Rosen who claimed to "never  
13 [have] had any enforcement responsibilities with respect to the Undertakings," "[n]or . . . any  
14 enforcement responsibilities with respect to the metrics listed in Undertaking 19." (*November*  
15 *16, 2009 "Declaration of Andrea Rosen in Support of California Department of Insurance's*  
16 *Motion to Quash the Request for Testimony of Andrea Rosen, or in the Alternative, to Strike Her*  
17 *Name From PacifiCare's Witness List" at 1:11-16).*

18 344. In fact, Ms. Rosen had held herself out to PLHIC and internally with senior CDI  
19 management as the person "responsib[le] for compliance with some of the United Undertakings  
20 including #19." (*Exh. 5287; Monk Tr. 8766:18-8768:16; Exh. 5427 (Rosen 3/14/07 email to*  
21 *PacifiCare Regulatory Affairs: "This meeting is premised on your company's ability to comply*  
22 *with not only the metrics of Undertaking 19, but the intent of this Undertaking" ))*

23 345. Several CDI witnesses also testified, and offered a supporting exhibit, that CDI had  
24 conducted an electronic analysis of over seven million claims processed by Blue Cross in its  
25 examination of Blue Cross in order to show that PLHIC had not been singled out when CDI  
26 conducted its electronic analysis of PLHIC paid claims for the 2007 MCE. (*Exh. 547,*  
27 *Washington Tr. 9622:7-9623:11, Dixon Tr. 5801:19-5802:5, Laucher Tr. 13153:22-13154:6)*

28

1           346. It turned out that CDI had not conducted such an analysis, but CDI admitted that  
2 fact only when PLHIC requested a copy of the Blue Cross electronic analysis. (*Exh. 877, at 1:6-*  
3 *12; Washington Tr. 14726:14-14727:23*)

4           347. CDI staff member Nicoleta Smith testified in the hearing that it took months to  
5 contact PLHIC representatives and that the phone kept “ringing and ringing” without answer  
6 until sometime in December 2006 (a point emphasized by CDI counsel during the trial), but Ms.  
7 Smith admitted on cross-examination that she was in contact with PLHIC representatives as  
8 early as the first week of November 2006. (*Exh. 5003; Smith Tr. 55:19-56:8, 184:10-185:21*)

9           348. Ms. Smith also substantially overstated the extent of the claims impact from  
10 PLHIC’s application of an incorrect pre-existing exclusionary period by a factor of four,  
11 reporting in an email that “4.5 million dollars is due thus far,” and continued to report to senior  
12 management that the matter had not been remediated when in fact it had been. (*Compare Exh.*  
13 *5019 with Exh. 601, p. 9162 and Exh. 5165*)

14           349. CDI also offered the testimony of Mrs. W to suggest that PLHIC’s conduct had  
15 resulted in a denial of medical care for her son, even though CDI executives and their counsel  
16 knew that Blue Cross, not PLHIC, had caused the denial of care to happen and that Mrs. W never  
17 contended that PLHIC was responsible. (*Exh. 5086; Cignarale Tr. 23313:23-23314:21,*  
18 *23326:5-19; Exhs. 5660, 5273; Cignarale Tr. 23344:14-12248:18*)

19           350. Mrs. W’s DMHC complaint against Blue Cross did not allege any wrongdoing by  
20 PLHIC, which had appropriately paid its share of liability for Mrs. W’s son’s treatment. (*Exh.*  
21 *5086; Cignarale Tr. 23317:17-23338:12, 23351:14-23353:21*)

22           351. Indeed, when CDI tried to solicit Mrs. W to appear at the January 25, 2008 press  
23 conference, Deputy Commissioner of Communications Byron Tucker asked Deputy  
24 Commissioner Cignarale if he was “sure this is related to [the PLHIC press conference]” after  
25 speaking with Mrs. W, and Mr. Cignarale responded “hopefully, she will stick to her Paccare  
26 [sic] case” and not mention any other insurer with whom she had disputes. (*Exh. 5273*)

27           352. As further evidence of its lack of objectivity with respect to Mrs. W’s matter, CDI  
28 staff cited PLHIC for 32 alleged violations in connection with Mrs. W’s complaint, but failed to

1 cite Blue Cross for even one violation despite the serious nature of her complaint against Blue  
2 Cross. (*Exhs. 134, 5720*)

3 353. CDI also asserted that PLHIC failed to disclose to CDI that it never sent written  
4 acknowledgment letters to providers prior to February 29, 2008 until PLHIC witnesses testified  
5 in this hearing. (*Exh. 664*)

6 354. Contrary to CDI's assertion, PLHIC disclosed this fact to CDI and its counsel in  
7 March 2008 in a meeting with Andrea Rosen, Jerry Whitfield and Craig Dixon and it did so in  
8 writing. (*Monk Tr. 8993:11-8996:7; Exhs. 808, 817, p. 6520*)

9 355. While CDI has alleged that PLHIC's written disclosures about claims  
10 acknowledgments were misleading, when shown that document, Deputy Commissioner  
11 Cignarale admitted there was nothing in it that led him to conclude "that letters were being sent  
12 to providers prior to" "March 1, 2008." (*Cignarale Tr. 23830:24-23832:3; Exh. 808*)

13 356. CDI then alleged that PLHIC, in substance, suborned perjury at trial by  
14 "sponsoring testimony from its employee that the [provider] acknowledgment letters were going  
15 out in February of 07." (*Stead Tr. 25131:2-4*)

16 357. CDI's allegation that PLHIC suborned perjury is unfounded and, in any event,  
17 PLHIC had provided CDI a complete explanation of these issues in March 2008.

- 18 a. First, PLHIC did not offer the testimony of Ms. Norket. She was called to testify  
19 by CDI. (*Norket Tr. 2268:4-5*)
- 20 b. Second, CDI counsel presented excerpts of Ms. Norket's testimony as one  
21 continuous line of questioning even though the excerpts were separated by pages of  
22 omitted testimony in which Ms. Norket made it clear that she was referring to  
23 member letters and not to provider letters ("In the context of acknowledgment  
24 letter, you know, I can't say . . . when they were printed and mailed. But I can say  
25 that was what my understanding was at the time. And also, since this time, I have  
26 understood that we were acknowledging claims to providers in other methods.")  
27 (*Exh. 1184, p. 122:3-13; CDI Prop. FOF ¶ 529; CDI Op. Br., at 228:17-25;*  
28 *Norket Tr. 2436:17-23*)

1 c. Third, even the excerpts CDI portrayed as a continuous line of questioning does not  
2 support CDI's contention, because Ms. Norket was testifying about her historical  
3 recollection when she said "[t]hat was the understanding that I had," and not her  
4 then-present views and understanding in January 2009. (*Norket Tr. 2436:17-23* )

5 358. CDI has nevertheless continued to rely on the same misleading excerpted provision  
6 to support its unfounded contention. (*Stead Tr. 25135:8- 25139:14-18*)

7 359. In the months leading up to commencement of the hearing in this matter, CDI staff  
8 reopened a number of previously closed complaint files (including some that had been closed for  
9 as long as two years), and cited PLHIC for an additional 156 violations. (*Exhs. 5692, 5693*)

10 360. Those additional cited violations were included in the "violations per complaint"  
11 calculations CDI used to compare PLHIC with other insurers. (*Exh. 1184, p. 7:1-13*)

## 12 **VII. DUE PROCESS CONSTRAINS THE AMOUNT OF ANY PENALTY.**

### 13 **A. CDI's Recommended Penalty**

14 361. CDI bases its penalty recommendation on a number of alleged violations of Section  
15 790.03 that exceeds the 90 included in CDI's final 2007 MCE Public Report and the initial OSC.  
16 (*Exhs. 1, 116*) For the reasons stated above, CDI cannot charge Section 790.03 violations that  
17 were not reported in the Public Report.

18 362. Even if the Court were to agree that the number of alleged violations of Section  
19 90.03 could exceed 90, the Court does not believe the penalty methodology relied upon by CDI  
20 is legally and equitably permissible.

21 363. CDI created a penalty methodology specifically for PLHIC in this case, which is  
22 "contrary to what . . . regulators do" when assessing penalties. (*Cignarale Tr. 23180:22-*  
23 *23181:4, 22768:25-22769:3, Stead Tr. 24279:15-24282:8*)

24 364. This penalty methodology has never been applied to an insurer other than PLHIC.  
25 (*Cignarale Tr. 23230:1-17; Exh. 5707, p. 3; Stead Tr. 24451:17-24452:7*)

26 365. In fact, Deputy Commissioner Cignarale testified that it was not even clear  
27 "[w]hether or not the Commissioner [will] decide" to use "the penalty methodology" in the  
28 future. (*Cignarale Tr. 23229:9-14*)

1           366. No one at CDI other than Mr. Cignarale participated in developing the penalty  
2 methodology used in this proceeding. (*Cignarale Tr. 23583:22-23584:16*)

3           367. Although Mr. Cignarale claimed in his Pre-Filed Written Testimony that he is  
4 qualified to offer a recommendation as to the penalty in this proceeding, Mr. Cignarale admitted  
5 to a lack of meaningful involvement in the setting or assessing of penalties, especially against  
6 health insurers for the specific charged violations in this proceeding.

7           a. Mr. Cignarale could not identify a single health insurer for which he was involved  
8 in assessing penalties in his 19 year career at CDI. (*Cignarale Tr. 22923:16-*  
9 *22924:1, 22927:4-9*)

10          b. Mr. Cignarale was unfamiliar with the 23 legal matters handled the CDI’s Health  
11 Enforcement Bureau in 2008 and reported in a section of CDI’s Annual Report  
12 discussing achievements in Mr. Cignarale’s department. (*Cignarale Tr. 22914:1-*  
13 *22919:25*)

14          c. Mr. Cignarale was not involved in assessing or setting the penalties in CDI’s  
15 enforcement actions against Blue Cross, Blue Shield or Health Net. (*Cignarale Tr.*  
16 *22923:13-15*)

17          d. Mr. Cignarale did not know details about the MEGA multi-state settlement even  
18 though it was the largest penalty imposed by a regulator against an insurer at the  
19 time and California was tasked with monitoring compliance under the agreement.  
20 (*Cignarale Tr. 23791:1-23795:17; Exh. 5671; Stead Tr. 24282:9-24285:25*).

21          e. Mr. Cignarale admitted that highest penalty that he could recollect ever having  
22 recommended was in the range of “over a million dollars.” (*Cignarale Tr.*  
23 *22928:15-22, 23622:11-19*)

24           368. CDI’s methodology assigned a generic penalty to each alleged violation before  
25 applying the factors set forth in 10 CCR 2695.12. (*Cignarale Tr. 23541:19-24, 23574:5-*  
26 *23576:5, Stead Tr. 24274:22-24275:4, 24277:22-24278:13; Exhs. 5706, 5712, p. 41*)

27           369. Each of the generic penalties that Mr. Cignarale devised was not tied to any  
28 “surveys or studies done by the Department,” or “any documentation to help inform what the

1 potential harm would be in any category of these alleged violations;” nor did CDI “go back and  
2 look at previous penalties assessed.” (*Cignarale Tr. 23227:21-23228:20, 23543:2-10, Stead Tr.*  
3 *24582:19-24583:16; Exh. 5707, p. 3*)

4 370. Based on his assigning to each category of violation a “generic penalty,” Mr.  
5 Cignarale arrived at a penalty of \$1.273 billion before even applying the factors in 10 CCR  
6 *Section 2695.12. (Exh. 5668)* After applying the factors in 10 CCR 2695.12, his penalty  
7 calculation increased to \$1.290 billion.

8 371. Mr. Cignarale’s application of the factors in *Section 2695.12* appeared to be  
9 without significance given that his aggregate penalty remained essentially unchanged. (*Exh.*  
10 *5707, p. 3, Exh. 5668, p. 1; Cignarale Tr. 23670:17-23 (identifying difference after applying*  
11 *factors as “not a large difference”*))

12 372. Mr. Cignarale admitted that he did not “make any effort to go back and look and  
13 see what penalties have [been] assessed [by CDI] or paid [by insurers] in connection with any of  
14 [the] categories [of charged violations in this case],” because he did not believe prior penalties  
15 assessed for the same violations were “relevant to assessing the penalty” against PLHIC.  
16 (*Cignarale Tr. 23228:4-15, 23721:4-12*)

17 373. CDI reduced its recommended penalty to \$325 million without any discernable  
18 “methodology and formula” based in part on a faulty assessment of PLHIC’s profitability.  
19 CDI’s analysis ignored financial data that PLHIC reported to CDI in the ordinary course of  
20 business that demonstrated that the PLHIC line of business operated at nearly a loss during the  
21 2006-2008 period. (*Cignarale Tr. 23176:7-16, 23177:16-20; Exh. 5707, p. 3*).

22 374. CDI’s recommended penalty bears no relationship to the total number of violations  
23 alleged by CDI; Mr. Cignarale admits that the recommended penalty would remain the same  
24 even if over 700,000 of the violations were struck from the case. (*Cignarale Tr. 23196:7-22,*  
25 *Stead Tr. 24296:13-24297:12*)

26 375. CDI’s recommended penalty of \$325 million constitutes the type of non-  
27 transparent, “black box” decision-making that regulators seek to avoid. (*Stead Tr. 24295:8-*  
28 *24296:12*)

1           **B.    Historical Penalties**

2           376. Dr. Daniel Kessler, a Stanford professor specializing in health care economics,  
3 provided persuasive testimony to support the view that a regulator should be consistent in  
4 assessing penalties against the entities it regulates. (*Exh. 5411; Kessler Tr. 20908:9-20911:1;*  
5 *see also Stead Tr. 24239:8-24240:11*)

6           377. Dr. Kessler is a senior fellow at Stanford’s Hoover Institution and a Research  
7 Associate at the National Bureau of Economic Research, the nation’s leading nonprofit,  
8 nonpartisan economic research organization. He is a one of the nation’s foremost authorities in  
9 the area of health care economics and deterrence theory, and he has published a number of  
10 writings on these subjects in peer-reviewed journals, and his research has been cited by the  
11 NAIC, among other organizations.

12           378. Dr. Kessler and Ms. Stead also presented persuasive evidence that the assessment  
13 of a penalty inconsistent with historical penalties would harm California consumers and the  
14 market more generally. (*Exh. 5621, p. 2, Exh. 5707, p. 4*)

15           379. CDI itself underscores the importance of the “Department to be consistent in its  
16 treatment of licensed entities” and to “fairly and impartially enforce the law” in its mission  
17 statement and the testimony of some of its senior management. (*Exh. 5407, 5708; Laucher Tr.*  
18 *13186:9-20, Stead Tr. 24236:7-24241:5*)

19           380. In this case, however, CDI’s recommended penalty is inconsistent with historical  
20 penalties CDI has assessed against other insurers. (*Exhs. 5706, 5708, 5712, 5622, 5632; Kessler*  
21 *Tr. 20913:9-20935:7, 22106:2-22107:18, Stead Tr. 24262:1-24267:21, 24311:2-24326:22*)

22           381. CDI identified four key enforcement actions in 2008 – all of which involved health  
23 insurers: Blue Shield, Blue Cross, Health Net and PLHIC. (*Exh. 5649*)

24           382. CDI designated each of these enforcement actions as high profile and severe in  
25 nature. (*Laucher Tr. 13047:4-13048:17, 13050:10-16, 14089:9-22*)

26           383. CDI nevertheless handled the PLHIC matter differently from the other key  
27 enforcement actions identified by CDI.

28

- 1 a. CDI resolved all of the key enforcement actions but the PLHIC action. (*Cignarale*  
2 *Tr. 23087:8-23089:8, 23089:25-23090:7*)
- 3 b. CDI relied on a sample to evaluate claims handling practices for each of these  
4 enforcement actions but in the case of PLHIC it evaluated the total population of  
5 claims. (*Exhs. 5422, 5423, 5417, 5419, 5420, 5506*)
- 6 c. CDI had the data and ability to analyze, at least for Blue Cross, compliance across  
7 the total population of claims, but it chose not to do so. (*Washington Tr. 14727:7-*  
8 *23*)
- 9 d. CDI gave each of the insurers except PLHIC an opportunity to fix its problems  
10 before seeking any kind of significant penalty. (*Laucher Tr. 14100:17-14103:24*)
- 11 384. CDI could have resolved the matter with PLHIC in the same way it did the other  
12 enforcement actions. (*Cignarale Tr. 23087:8-23089:8, 23089:25-23090:7*)
- 13 385. In the Blue Shield matter, CDI assessed no penalty against Blue Shield as long as  
14 Blue Shield corrected its issues. However, even if Blue Shield failed to correct those issues, the  
15 penalty for not doing so -- which was never imposed -- would not exceed \$5 million. (*Laucher*  
16 *Tr. 13247:5-13250:2; Exh. 5419*)
- 17 a. The Blue Shield action involved claims-handling issues similar to those alleged  
18 here, but unlike the PLHIC action, the Blue Shield action also involved millions of  
19 additional dollars in claims impact as a result of an alleged practice of illegal  
20 rescissions. (*Exh. 5419; Laucher Tr. 13231:24-13232:20, 13238:2-13239:3,*  
21 *13275:20-13279:25*)
- 22 386. In the Blue Cross matter, CDI assessed a penalty of \$1 million for an alleged  
23 practice of illegal rescission and for alleged claims-handling issues over a two year period, with a  
24 back end penalty of \$2 million if Blue Cross failed to “substantially correct” the issues. (*Exh.*  
25 *5420; Laucher Tr. 13258:5-13260:15, 13309:20-13312:4*)
- 26 a. The Blue Cross action involved over \$14 million in claims impact from the alleged  
27 practice of illegal rescissions and claims-handling issues that affected a population  
28

1 of 7.6 million claims, as opposed to PLHIC, which had no claims impact from  
2 illegal rescissions. (*Exhs. 547, 5633; Washington Tr. 14740:3-14742:8*)

3 b. Blue Cross had significantly greater claims volume as compared to PLHIC and  
4 more than four times the number of members.

5 c. CMA data showed a substantially higher level of claim payment issues as a  
6 percentage of total complaints post-merger for Anthem/Blue Cross than for  
7 PacifiCare. (*McNabb Tr. 20423:23-20425:23; Exh. 5615, p. 5; see also 5621,*  
8 *App. F*)

9 387. In the Health Net matter, CDI assessed a penalty of \$3.6 million for an alleged  
10 practice of illegal rescission and for alleged claims-handling issues. (*Exh. 5423*)

11 a. The Health Net action involved over \$22 million in claims impact from the alleged  
12 practice of illegal rescission and claims-handling issues that affected a population  
13 of 2,477,929 claims. (*Exhs. 5366, 5573; see also Public Report of the Market*  
14 *Conduct Examination of Health Net Life Insurance Co., January 27, 2006*)

15 388. The penalty amounts ultimately imposed by CDI against Blue Cross and Health  
16 Net were not constrained by the maximum cap in Section 790.035. (*Kessler Tr. 22104:1-*  
17 *22107:23*)

18 389. By contrast, PLHIC was not accused of having illegally rescinded any member's  
19 coverage and paid less than \$1 million in connection with the issues identified in the 2007 MCE,  
20 most of which was paid before PLHIC even received notice of CDI's intention to conduct a  
21 targeted examination of PLHIC.

22 390. Though CDI conducted a joint investigation of PLHIC with the DMHC, and  
23 coordinated the issues in the case, CDI's proposed penalty also departs significantly from the  
24 penalty DMHC assessed.

25 391. DMHC assessed a penalty of \$2 million for the same period and same issues based  
26 on roughly ten times more volume of DMHC-regulated business than the CDI-regulated business  
27 at issue here. (*Exhs. 5320, 5620*)

28

392. The penalty CDI recommends here is exponentially higher than any penalty that CDI has historically assessed and is almost ten times higher than all the penalties assessed by CDI in the 8 years preceding this enforcement action -- a time period when CDI initiated 74 enforcement actions.

<u>Year</u>	<u>Penalties Resulting from Market Conduct Division Legal Actions (Per CDI Annual Report)</u>	<u>Number of Actions Finalized by Legal Branch Due to Market Conduct Division Exam Findings</u>
2002	\$776,500	4
2003	\$1,264,157	11
2004	\$1,750,000	9
2005	\$14,683,000	17
2006	\$1,227,000	10
2007	\$10,545,500	10
2008	\$4,700,000	7
2009	\$2,465,000	6
<b>TOTAL</b>	<b>\$37,411,157</b>	<b>74</b>

*(Exhs. 5569, 5570, 5571, 5622, 5632 and 5708)*

393. The largest penalty CDI has assessed against a disability insurer totaled \$8 million and involved far more serious allegations. That insurer, Unum, denied disability benefits to 26,000 California residents totaling approximately \$50,000,000 in claims impact. *(Exhs. 5697, 5718; Stead Tr. 24313:14-24314:21)*

394. CDI's contention that it can ignore prior historical penalties because they all involved situations where CDI resolved the actions short of a final administrative decision is unsupported by any legal or factual precedent. *(Stead Tr. 24577:23-24580:20, Cignarale Tr. 23149:1-7, 24131:12-24132:5, 23760:2-11, 24135:9-24136:18, Zaretsky Tr. 18658:16-18659:1, Strumwasser Tr. 25678:24-25680:10)*

395. The Commissioner has the same obligation to apply the laws fairly and impartially whether the matter is resolved short of hearing or not, and he is required to publish any penalties that are the result of a stipulated action. *(Cignarale Tr. 23210:14-23213:7, Stead Tr. 24302:15-*

1 [24303:12; CIC § 12938](#); see also *Powertrain Warranty, Inc., June 15, 2004* (“According to  
2 section 790.05, when the commissioner has reason to believe that someone has engaged in  
3 methods, acts, or practices defined in section 790.03, the Commissioner must act”))

4 396. Insurance Code [Section 12938](#) requires that CDI publish any penalties assessed  
5 against a licensed entity including those resolved by way of settlement. One purpose is to  
6 provide notice to the industry ([Stead Tr. 24260:25-24264:23](#)), and, in fact, the current  
7 Commissioner has explicitly acknowledged the use of settlements for purposes of providing  
8 notice to the industry. (*See Ex. 5711 and Stead Tr. 24264:24-24266:4.*)

9 397. Settlements in the regulatory context may actually be higher than what might occur  
10 in litigation because insurers are incentivized to resolve matters with a regulator quickly.  
11 ([Kessler Tr. at 22100:7-11201:22](#))

12 398. The Department was not “forced to bring this action through to administrative  
13 hearing” and “could have resolved this matter just like Blue Cross, Blue Shield and Health Net.”  
14 ([Cignarale Tr. 23089:19-23090:7](#))

15 399. Although CDI purports to justify its large penalty against PLHIC based on the  
16 number of alleged violations in this proceeding as compared to actions involving other insurers,  
17 CDI relied on violations for sampled files in those other cases. If CDI had applied the same  
18 approach to calculating alleged violations in those other cases that it did here, *i.e.*, reviewing a  
19 total claims population as opposed to sample, and citing every violation in the population as  
20 opposed to just the ones identified in the sample, then the number of violations in several of  
21 those other actions would be equal to or significantly greater than those in this proceeding.  
22 ([Cignarale Tr. 23362:24-23380:16; Exh. 5712, p. 41; Exhs. 5540, 5661](#)).

23 **C. Range of Potential Penalty Based Upon Historical Penalties**

24 400. PLHIC’s expert Dr. Kessler developed a reasonable methodology to calculate a  
25 range of potential penalties in this proceeding that would be consistent with CDI’s historical  
26 penalties and when he applied this methodology to the facts of this case, he concluded that the  
27 acceptable penalty range would fall between \$0 and \$650,000 consistent with that methodology.  
28 ([Kessler Tr. 20925:3-20935:7; Exhs. 5621, 5622](#))

1 401. PLHIC’s regulatory expert Susan Stead corroborated the approach utilized by Dr.  
2 Kessler as consistent with how regulators assess penalties. (*Stead Tr. 26149:2-26151:22*)

3 402. Ms. Stead confirmed that a regulator will examine historical penalties for similarly  
4 situated insurers (*i.e.*, in this instance, health insurers) and establish a potential penalty range  
5 after accounting for differences in harm, including membership impact. (*Stead Tr. 26143:23-*  
6 *26151:9*)

7 403. CDI’s penalty expert admitted he was “not in a position” to challenge the  
8 methodology employed by Dr. Kessler. (*Cignarale Tr. 23757:5-8, 23757:11-16*)  
9 The evidence does not support finding any extenuating or special circumstances that would  
10 justify assessing a penalty outside that range.

11 **VIII. CDI HAS FAILED TO ESTABLISH THAT PLHIC’S CONDUCT**  
12 **VIOLATED SECTION 790.03**

13 **A. Alleged Violations Arising from Individual Provider and Member**  
14 **Complaints (First Amended OSC, ¶¶ 2-98)**

15 404. In the First Amended Order to Show Cause, CDI alleges violations related to 21  
16 provider and 76 member complaints handled by its Consumer Services Bureau.

17 405. 11 of the 21 provider complaints are outside the 2007 MCE period.

18 406. 34 of the 76 member complaints are outside the 2007 MCE period.

19 407. None of the 21 providers whose complaints are described in the First Amended  
20 OSC testified in this action. Rather, CDI relies on closure letters issued by its Consumer  
21 Services Bureau to support the alleged violations in this proceeding.

22 408. With the exception of Mr. R and Mrs. W, none of the members whose complaints  
23 are described in the First Amended OSC testified in this action. Rather, for those 74 member  
24 complaints, CDI relies on closure letters issued by its Consumer Services Bureau to support the  
25 alleged violations in this proceeding.

26 409. CDI’s closure letters contain conclusory statements that PLHIC committed one or  
27 more violations, do not attach any documentary evidence of the underlying allegations, do not  
28 provide the necessary details by which a reasonable trier of fact could assess the charged

1 violations, and did not provide PLHIC with an opportunity to contest CDI’s findings, in all  
2 instances stating “[n]o response to this letter is required.” (*See, e.g., Exh. 40, 41*)

3 410. The closure letters are administrative hearsay that cannot form the basis for a  
4 factual finding without other competent evidence, which CDI failed to submit. (*Govt. Code §*  
5 [11513\(d\)](#)). By themselves, the closure letters do not prove the charged violations.

#### 6 Charged Violations Arising Out of Individual Complaints

7 CDI pleads a number of alleged violations arising out of the individual complaints in its  
8 First Amended OSC. Some of the categories of alleged violations are unique to the individual  
9 complaints, which PLHIC addresses in Sections M, N, R & T below, while other alleged  
10 violations fall within the larger categories of violations (e.g., allegedly non-compliant EOBs or  
11 EOPs) described in Sections B and C below.

12 Moreover, specific facts relative to the two member witnesses who testified are set forth  
13 in [Section V](#) below.

#### 14 **B. Alleged Violations Arising from Failing to Give Notice to Providers of** 15 **Their Right to Appeal to CDI (First Amended OSC, ¶¶ 126-133)**

16 411. [Section 10123.13](#) and [10123.137](#), both enacted at the same time, impose two notice  
17 requirements on a health insurer’s form EOPs: (a) a provider’s right to participate in the  
18 company’s formal provider dispute resolution (“PDR”) process, and (b) a provider’s right to seek  
19 CDI review in the event of a contested or denied claim.

20 412. The requirement in [Section 10123.13\(a\)](#) that insurers give notice of the right to CDI  
21 review in provider EOPs became effective on January 1, 2006, only six months before  
22 commencement of the 2007 MCE Period.

23 413. PLHIC had an established process for reviewing new legislation and reporting any  
24 new regulatory requirements. (*Monk Tr. 8891:12-8893:6*)

25 414. In 2005, there were over thirty (30) separate pieces of legislation that were  
26 implemented that potentially impacted PLHIC’s operations, including these notice requirements.  
27 (*Monk Tr. 8901:3-5*)

28

1 415. PLHIC personnel responsible for implementing the notice requirements for PDR  
2 and right to CDI review erroneously “implemented the notice requirements as though there was  
3 only one notice requirement related to the plan’s internal provider dispute mechanism.” (*Monk*  
4 *Tr. 8895:3-25, 8896:18-8899:4, 9271:14-21*)

5 416. PLHIC “was not cited in the 2006 Report for any” alleged violations related to non-  
6 compliant EOPs by CDI in the Draft 2006 [MCE] Report.” (*Exh. 5181; David Tr. 11430:24-*  
7 *11431:11, 11578:5-9*)

8 417. Since the time CDI brought the EOP issue to PLHIC’s attention, the company has  
9 included the required form language, and improved its processes for review and implementation  
10 of new legislation and has done so, in large part, by adopting United’s processes in that area.  
11 (*Monk Tr. 8889:4-20, 8900:8-22, 9293:1-19, 9297:21-9299:2; Exhs. 5314, 5049*)

12 418. The failure to include the right to CDI review notice language in EOPs was  
13 inadvertent. (*Monk Tr. 8899:19-8900:1*)

14 419. Despite the fact that CDI right of review notice requirement in [Section 10123.13\(a\)](#)  
15 only applies to “contested or denied claims,” CDI has charged all PLHIC’s EOPs as non-  
16 compliant. (*CDI Opening Merits Brief, p. 69:19-21, 137:19-24; Cignarale Tr. 22937:1-*  
17 *22938:20, 23186:5-23187:8*)

18 420. CDI’s basis for charging all of PLHIC’s EOPs as non-compliant rests on its new,  
19 never before published interpretation that any claim that is not paid at billed charges (i.e., the  
20 provider’s standard rate for the service), is considered a “contested or denied claim” even if the  
21 claim was paid at the contracted, agreed-upon rate between the insurer and provider.

22 421. CDI has never previously taken the position publicly that CDI “right of review”  
23 language was required on all EOPs. (*Cignarale Tr. 22830:18-22831:7, 22942:4-22943:6, Stead*  
24 *Tr. 24340:16-24341:2*)

25 422. No statute, regulation or CDI internal rule requires right of review language on  
26 every EOP, or defines “contested or denied” in the manner proffered by CDI in this hearing.  
27 (*Masters Tr. 1864:1-4, David Tr. 11392:11-24, Cignarale Tr. 22831:25-22832:6, 22940:9-*  
28 *22942:12; Exh. 1197*)

1           423. CDI’s current definition of a “denied claim” directly conflicts with the definition it  
2 used in the 2007 MCE. There, CDI defined paid claims as those with any amounts paid. (*Exh.*  
3 *5187, p. 5606*). CDI’s interpretation of “contested or denied” also contradicts the generally  
4 accepted usage of the phrase within the insurance industry generally (*Exh. 821; Stead Tr.*  
5 *24342:12-24343:6*), other regulators specifically (*Exh. 5199, p. 312-313*), and CDI’s historical  
6 practice. (*Stead Tr. 24343:7-24345:19; Exhs. 5651, 5694, 5695, 5696; see also Stead Tr.*  
7 *25541:25-25542:18, 25555:12-25557:19*)

8           424. CDI is charging PLHIC for allegedly non-compliant forms outside of the 2007  
9 MCE period (June 1 to June 15, 2007), resulting in approximately 49,348 alleged violations that  
10 relate to a separate market conduct examination that is still currently underway.

11           425. PLHIC cooperated in amending its form EOPs to include CDI “right of review”  
12 language and did so within a reasonable time frame. (*Stead Tr. 24989:14-18, 25532:23-*  
13 *25533:24*)

14           426. Internal PLHIC communications characterized the EOP project as an “urgent” one  
15 from the outset. (*Exh. 5432; Diaz Tr. 13446:22-13447:6*)

16           427. CDI did not expect revised forms any earlier than April 30, 2007 (*Smith Tr.*  
17 *172:20-173:7*) and they were ready to be distributed at that time. (*Exh. 5306; Monk Tr.*  
18 *8872:13-8873:17. See also, Exhs. 11, 5357, 5359; Monk Tr. 9244:20-9245:21, Diaz Tr.*  
19 *13523:15-25 (changing deadline from April 8, 2007)*)

20           428. At the same time PLHIC was correcting the language in the form EOP, it was  
21 correcting language in its form EOB. The EOB and EOP modifications were treated as a single  
22 corrective action project (*Monk Tr. 8901:24-8902:7*) and PLHIC employees believed they were  
23 “at the verge of arriving at resolution with the Department” on modifications to the EOB, which  
24 caused the process for finalizing changes to both forms to be delayed by six weeks. (*Monk Tr.*  
25 *8872:13-8873:17, 9305:20-9306:4*)

26           429. The form EOPs and EOBs involved the same legal company product, scope,  
27 population of claims and claims platform. Combining the two revisions into one corrective  
28

1 action activity minimized the number of times the RIMS system needed to be re-programmed.  
2 (*Monk Tr. 8901:24-8092:7, 9305:1-9306:9, Stead Tr. 25532:10-25533:24*)

3 430. PacifiCare implemented the required changes to its form EOP and EOB on June 8,  
4 2007, and made minor typographical changes to the EOB on June 15, 2007. (*Exhs. 5314, 5049;*  
5 *Monk Tr. 8889:4-20*)

6 431. CDI has accepted significantly longer time periods by insurers to modify allegedly  
7 non-compliant EOBs and EOPs without assessing any penalty. (*Stead Tr. 26127:20-26128:18*)

8 432. PLHIC's failure to include language in its form EOP about the right of CDI review  
9 constituted, at most, a single act in violation of [Section 10123.13\(a\)](#). (*Stead Tr. 24438:20-*  
10 *24440:12*)

11 433. The failure to include CDI "right of review" language on form EOPs stems from, in  
12 essence, a single decision at the point the persons responsible for implementing the requirements  
13 for [CIC § 10123.13\(a\)](#) mistakenly construed the statute. (*Monk Tr. 8896:18-8899:4, 8899:19-*  
14 *8900:1*)

15 434. CDI has departed from its historical practice in this proceeding by citing every  
16 allegedly non-compliant form that PLHIC issued for a particular time period.

- 17 a. In a number of other examinations and enforcement actions, CDI cited only one "in  
18 general" violation for having an incorrect form, even though it was aware of much  
19 more widespread non-compliance. (*See, e.g., Standard Insurance Co. 2/29/09*  
20 *MCE Report (citing on "in general" 10123.13(a) violation for failing to put CDI*  
21 *Review Right language in EOPs), Unicare Life & Health Insurance Company*  
22 *11/12/10 MCE Report (citing one "in general" 10123.13(a) violation for failure to*  
23 *provide CDI address on EOPs), Symetra Life Insurance 10/9/07 MCE Report*  
24 *(citing one "in general" violation of 2695.7(b)(3) for failing to include CDI Right*  
25 *of Review language in EOBs), Hana Home Protection 5/29/08 MCE Report (citing*  
26 *one "in general" violation of 2695.7(b)(3) for failure to provide CDI Right of*  
27 *Review language [Reg. Off. Not. Tabs 20, 28, 30 34])*)

1           b. In the Blue Shield and Blue Cross examinations, CDI only cited the number of non-  
2           compliant forms in the sample as violations, even though it was aware that the  
3           insurers had many more violations across the overall claims population. (*Stead Tr.*  
4           *25255:1-25256:5; Exhs. 5418, 5479*)

5           435. Even in the 2007 MCE report on PLHIC, CDI chose not to treat each allegedly  
6           non-compliant EOP form as a separate violation. (*David Tr. 11575:3-11577:22, Kessler Tr.*  
7           *21303:15-21306:21; 21313:1-21314:9*)

8           436. There is no evidence that any provider was harmed by failing to receive CDI right  
9           of review language on an EOP. (*Kessler Tr. 20876:16-20877:4, Wetzel Tr. 16882:4-16,*  
10          *16937:22-16939:16, Zaretsky Tr. 19000:4-10, Cignarale Tr. 23973:7-23974:13; Exh. 5505*)

11          437. One expects providers to be better informed about their rights than consumers.  
12          (*Kessler Tr. 20872:17-21, Stead Tr. 25065:23-25066:8*)

13          438. Providers actively lobbied for a right of review and CDI was required to publicize  
14          the new law in a variety of forms, including on its website. (*Kessler Tr. 20873:3-10*)

15          439. CMA educated its members about the newly created right to CDI review under SB  
16          367 and 634. (*Wetzel Tr. 16713:18-16714:3, 16716:11-16718:25*)

17          440. There is no evidence that any provider ever complained about the lack of notice of  
18          CDI right of review on PLHIC's form EOP. (*Smith Tr. 271:8-272:17*)

19          441. PLHIC did not experience any material increase in the number of providers who  
20          sought CDI intervention regarding claims issues in the period following the addition of CDI right  
21          of review language on EOPs. (*Exh. 5317; Monk Tr. 8902:20-8903:25, Kessler Tr. 20873:14-*  
22          *20876:25*)

23          442. The number of complaints CDI deemed to be justified against PLHIC declined  
24          following inclusion of "right of CDI review" language on the form EOPs. (*Exh. 5622; Kessler*  
25          *Tr. 20873:14-20876:25*)

26          443. PLHIC received no notice that the non-compliant form violated Section 790.03.  
27          (*Kessler Tr. 22024:10-23, Cignarale Tr. 22943:10-21, 23016:1-23019:9*)

28

1 444. In the final 2007 MCE reports for PLHIC, CDI acknowledged the CDI “right of  
2 review” issue as “something other than violations of Section 790.03,” despite having a legal  
3 obligation to report any violations of Section 790.03 in the public MCE report. (*Cignarale Tr.*  
4 *22837:3-10, 23016:1-23019:9, Stead Tr. 24416:9-24417:8*)

5 445. Those 2007 MCE reports and the conclusions therein were approved by CDI senior  
6 management. (*Cignarale Tr. 23011:17-23013:24*)

7 446. The original OSC did not plead the alleged violations around the EOP as violations  
8 of Section 790.03, and when CDI later purported to amend the Public Report at the beginning of  
9 this enforcement hearing, it also did not include these allegedly non-compliant form EOPs as  
10 violations of Section 790.03. (*Cignarale Tr. 23025:12-23026:24; Exhs. 1, 123*)

11 447. Although CDI now asserts that PacifiCare’s failure to include right to CDI review  
12 language on provider EOPs is a violation of CIC § 790.03(h)(1) and CCR § 2695.7(b)(3), those  
13 laws only apply to “claimants,” which according to CDI’s own internal guidelines does not  
14 include providers. (*Exh. 1197; Stead Tr. 26131:16-26132:3*)

15 **C. Alleged Violations Arising from Failing to Give Notice to Insureds of**  
16 **Their Right to Request an Independent Medical Review (First Amended**  
17 **OSC, ¶¶ 134-140)**

18 448. A member is entitled to an Independent Medical Review (“IMR”) in only limited  
19 instances defined under Insurance Code sections 10169(d), (j) and (k). (*Masters Tr. 3945:23-*  
20 *3946:8, Roy Tr. 5713:9-5714:5, Monk Tr. 8874:19-8876:20*)

21 449. During the time period that is the focus of these charged violations, only 57 group  
22 product claims out a total of 336,267 claims adjudicated were potentially eligible for an IMR.  
23 (*Exh. 5298, p. 4; Cignarale Tr. 23969:7-20*)

24 450. Since enactment of the Section 10169 in January 2001, PLHIC advised members  
25 about their potential right to an IMR, including details about procedures for requesting an IMR,  
26 from the very outset of the company’s relationship with the member. (*Exh. 5299; Monk Tr.*  
27 *8855:18-8857:12*)

28

1           451. PLHIC also notified the member of his or her right to an IMR at the time the  
2 member has the right to request an IMR and includes an application form to minimize the burden  
3 on the member. (*Exhs. 5300, 5301, 5302; Monk Tr. 8859:2-8861:2*)

4           452. A member who receives a claim denial through an EOB is not eligible to request an  
5 IMR until he or she has completed the company’s grievance process. (*Monk Tr. 8860:24-*  
6 *8861:13, 8865:9-17; Stead Tr. 24346:9-19; Exh. 5305*)

7           453. Thus, including IMR disclosures in an EOB may confuse or mislead a member  
8 with regard to his or her right to an IMR and cause the member to request an IMR before he or  
9 she is entitled to such a right. (*Monk Tr. 8860:24-8861:13, Stead Tr. 25619:9-25620:4*)

10           454. The Legislature has expressly referred to EOBs in provisions of the Insurance  
11 Code, but Section 10169(i) does not identify an EOB as a document that requires IMR  
12 disclosures. (*Roy Tr. 5714:19-5715:12, Cignarale Tr. 22818:13-19); CIC Section 10123.13(a)*)

13           455. An EOB is not a “letter of denial” or a “copy of the insurer’s procedures for  
14 resolving grievances” as those phrases are understood within the insurance industry. (*Stead Tr.*  
15 *24346:9-24347:6, 25325:22-25326:11, 25580:21-25582:1, 25620:18-25621:10, Cignarale Tr.*  
16 *23362:11-23363:5*)

17           456. To the extent that PLHIC had an obligation to include IMR language in its EOBs  
18 and failed to do so, such failure was inadvertent. (*Monk Tr. 8866:10-20*)

19           457. CDI first notified PLHIC that it needed to include IMR language in EOBs on  
20 March 23, 2007. (*Exh. 5303; Smith Tr. 273:5-274:7 (first ‘general’ letter), Monk Tr. 8863:9-14*)

21           458. Prior to that time and during the six year period the statute had been in effect, CDI  
22 never “raised the issue [that] IMR language should be included on EOBs,” or cited PacifiCare for  
23 failing to include such notice despite CDI’s repeated review of PLHIC’s EOBs. (*Monk Tr.*  
24 *8865:18-8866:8*)

25           459. CDI did not cite PLHIC for allegedly failing to include an IMR notice in its EOBs  
26 in the 2006 Routine Exam. (*Exh. 5181*)

27  
28

1           460. The first time CDI cited PLHIC for failing to include IMR language in an EOB was  
2 in connection with a “special [or VIP] complainant” whose paid claim wouldn’t have triggered  
3 an independent medical review. (*Stead Tr. 24399:20-24401:7, 25932:10-13; Exhs. 37, 5651*)

4           461. Deputy Commissioner Cignarale “[couldn’t] explain why” PLHIC was never  
5 previously cited for its allegedly non-compliant EOBs. (*Cignarale Tr. 24071:16-24073:19*)

6           462. Before it served the OSC in this case, CDI “never has issued a bulletin or any kind  
7 of notice to the industry making clear” its position that insurers must include IMR language in  
8 EOBs, or that the failure to include IMR language in an EOB constitutes a violation of Section  
9 790.03. (*Monk Tr. 8863:9-14, Cignarale Tr. 22818:20-24, 22830:18-22831:7, 22834:8-  
10 22856:11, Stead Tr. 24257:2-24258:18*)

11           463. CDI does not have any “documentation . . . internal manual or procedures within  
12 the Department” that supports its position that insurers must include IMR language in EOBs.  
13 (*Cignarale Tr. 22817:10-15*)

14           464. Major health insurers doing business in California did not include IMR language on  
15 their form EOBs. (*Exhs. 5540, 5561; Cignarale Tr. 23363:9-23371:15, 23369:22-23371:15,  
16 23376:5-23378:11*) Ex. 5661

17           465. CDI knew these other insurers were also not including IMR notice on their EOBs.  
18 (*Cignarale Tr. 23368:11-25, 23380:5-16, 23387:8-20, Stead Tr. 24348:1-24350:7*)

19           466. PLHIC cooperated in amending its EOBs to include notice of IMR rights, and did  
20 so within a reasonable time. (*Stead Tr. 24983:5-14, Monk Tr. 8871:11-8872:19, 8867:11-16,  
21 8878:9-8889:20, Diaz Tr. 13460:3-13469:2 (lengthy testimony re: back-and-forth with CDI to  
22 settle on language)*)

23           467. PLHIC expressly informed CDI that it would not implement EOBs with the new  
24 IMR language until it had reached agreement with CDI on the specific language CDI desired.  
25 (*Exh. 14, Exh. 15, Exh. 16, Exh. 5306; Smith Tr. 11077:6-16*)

26           468. From March 2007 to June 2007, PLHIC worked with CDI staff to develop  
27 language acceptable to CDI. (*Monk Tr. 8867:11-16, 8878:9-8889:20, Diaz Tr. 13460:3-13469:2  
28 (lengthy testimony re: back-and-forth with CDI to settle on language)*)

1           469. Internal company communications characterized the EOB project as an “urgent”  
2 one from the outset. (*Exh. 5432; Diaz Tr. 13446:22-13447:6*)

3           470. CDI does not have any internal or publicly available writing that sets forth  
4 acceptable IMR language to include on an EOB. (*Exhs. 5033, 5034; Masters Tr. 530:20-534:15,*  
5 *1805:14-1806:25, Diaz Tr. 13454:11-13455:18*)

6           471. CDI currently asserts that PLHIC could have used the sample language referenced  
7 in Robert Masters’ March 27, 2007 letter; however, substantially similar language was later  
8 criticized by CDI staff as being non-compliant. (*Exhs. 5303, 5309, 5311*)

9           472. Robert Masters’ March 27, 2007 letter does not purport to include IMR language  
10 that would be considered compliant by CDI to include in a form EOB. (*Exh. 5303*) The letter  
11 explicitly states that it is for “reference” only and that it is PLHIC’s responsibility to compose  
12 compliant language. *Id.*

13           473. CDI never directed PLHIC to complete its revisions to its form EOBs by a certain  
14 date. The target revision dates were suggested by PLHIC and PLHIC kept CDI staff informed of  
15 any changes in that schedule. (*Smith Tr. 173:14-23, 273:21-277:16; Exhs. 14, 15 and 16; Exhs.*  
16 *5303, 5308, 5309, 5311, 5356, 5357, 5358, 5359, 5360, 5363, 5368 p.4*)

17           474. CDI did not expect a revised EOB form any earlier than April 30, 2007 (*Smith Tr.*  
18 *172:20-173:7*) and PLHIC delivered a revised form at that time. (*Exh. 5306; Monk Tr. 8872:13-*  
19 *8873:17, Smith Tr. 276:6-25*)

20           475. The version of IMR language initially proposed by PLHIC is identical to the form  
21 language endorsed by the Industry Collaborative Effort (“ICE”), a managed care and insurance  
22 industry educational organization in which CDI participates. (*Monk Tr. 18038:12-18040:23;*  
23 *Exhs. 5357, 5544*)

24           476. PLHIC had planned to implement the initial version sent to CDI, but CDI  
25 responded that the changes did not contain “adequate language.” As a result, PLHIC informed  
26 CDI that “new EOB changes will be made once [we have] had an opportunity to discuss the new  
27 IMR changes to be made.” (*Smith Tr. 276:5-277:16, 11041:4-11042:6; Exh. 5359*)

28

1 477. PLHIC met of its each revised implementation target dates, but each time CDI staff  
2 raised new objections to PLHIC’s revised IMR notice language. (*Smith Tr. 279:4-25, 11029:10-*  
3 *11030:12, 11075:5-24, 11080:5-10, 11086:13-11090:11, Monk Tr. 8878:12-8879:16, 8889:10-*  
4 *17, Diaz Tr. 13458:15-13460:22, 13523:10-13524:13; Exhs. 5306, 5308, 5309, 5391)*

5 478. Nicoleta Smith claimed that she expected the Company to implement her numerous  
6 “suggestions” to its form EOB, but admitted she never once told PLHIC that it “should start  
7 implementing the revised language” in the interim while CDI staff further reviewed the forms.  
8 (*Monk Tr. 8886:2-8887:14, 9244:20-9245:11, Smith Tr. 11044:18-11046:13, 11056:2-11057:4,*  
9 *11064:11-19, 11072:24-11073:15)*

10 479. PLHIC demonstrated that there “was disagreement amongst [CDI] staff about what  
11 would be acceptable [IMR] language” on EOBs, and that CDI gave PacifiCare conflicting  
12 information. (*Exh. 5361; Smith Tr. 11110:12-11111:14, 11119:19-11120:5, Roy Tr. 5719:17-*  
13 *5722:25; Masters Tr. 531:21-534:13; Diaz Tr. 13454:11-21)*

14 480. One would not expect an insurer to implement changes to a form when the  
15 regulator had not agreed to what those changes should look like. (*Stead Tr. 24988:13-22,*  
16 *25532:3-24)*

17 481. PLHIC made every change to the form EOB requested by CDI and finalized the  
18 EOB form for publication on June 8, 2007, only days after Ms. Smith “approved” it on June 4,  
19 2007. (*Monk Tr. 8878:19-22, 8882:1-7, Diaz Tr. 13463:9-13465:17)*

20 482. Although CDI and Ms. Smith claim in this proceeding that Ms. Smith did not  
21 “approve” PLHIC’s final EOB form and IMR language, PLHIC’s Jean Diaz provided  
22 contemporaneous evidence to the contrary.

23 a. In a handwritten note from a telephone conversation she had with Mr. Smith on  
24 June 4, 2007, Ms. Diaz recounted that Ms. Smith had “approved” that version. . .  
25 (*Exh. 5436; Diaz Tr. 13466:19-13469:2)*

26 b. Ms. Diaz also included the EOB revision project on a corrective action update log  
27 that she provided to Ms. Smith from time to time. On the June 21, 2007 version of  
28 this log that Ms Diaz sent to and discussed with Ms. Smith, Ms. Diaz wrote in the

1 row entry for the EOB revision project that “CDI approved changes on 6/4/07.”

2 Neither Ms. Smith nor anyone else at CDI who received that log ever informed Ms.

3 Diaz that CDI had not, in fact, “approved” PLHIC’s EOB form. (*Exh. 5438, p.*

4 *4442; Diaz Tr. 13470:13-13472:12*)

5 483. CDI has accepted significantly longer time periods in which insurers modified  
6 allegedly non-compliant EOBs without assessing any penalty. (*Stead Tr. 26128:2-18*)

7 484. PLHIC’s failure to include IMR disclosure language in its EOBs constituted, at  
8 most, a single act in violation of Section 10169(i). (*Stead Tr. 24397:3-24399:16, 24438:20-*  
9 *24440:12; see also Monk Tr. 9257:7-13*)

10 485. CDI has departed from its historical practice in this proceeding by citing every  
11 allegedly non-compliant form that PLHIC issued for a particular time period.

- 12 a. In the 2007 MCE report on PLHIC, CDI chose not to treat each EOB form as a  
13 separate violation. (*David Tr. 11575:3-11577:22, Kessler Tr. 21303:15-21306:21,*  
14 *21313:1-21314:9*)
- 15 b. In a number of other examinations and enforcement actions, CDI cited only one “in  
16 general” violation for an incorrect form even though it was aware of much more  
17 widespread non-compliance. (*See, e.g., Standard Insurance Co. 2/29/09 MCE*  
18 *Report (citing on “in general” 10123.13(a) violation for failing to put CDI Review*  
19 *Right language in EOPs), Unicare Life & Health Insurance Company 11/12/10*  
20 *MCE Report (citing one “in general” 10123.13(a) violation for failure to provide*  
21 *CDI address on EOPs), Symetra Life Insurance 10/9/07 MCE Report (citing one*  
22 *“in general” violation of 2695.7(b)(3) for failing to include CDI Right of Review*  
23 *language in EOBs), Hana Home Protection 5/29/08 MCE Report (citing one “in*  
24 *general” violation of 2695.7(b)(3) for failure to provide CDI Right of Review*  
25 *language [Reg. Off. Not. Tabs 20, 28, 30, 34])*)
- 26 c. In the Blue Shield and Blue Cross examinations, CDI only cited the number of non-  
27 compliant forms in the sample as violations, even though it was aware that the  
28

1 insurers had many more violations across the overall claims population. (*Stead Tr.*  
 2 *25255:1-24; Exhs. 5418, 5479*)

3 486. CDI is charging PLHIC for allegedly non-compliant forms outside of the 2007  
 4 MCE period (June 1 to June 15, 2007), resulting in approximately 49,348 alleged violations that  
 5 relate to a separate market conduct examination that is still currently underway.

6 487. CDI could not identify a single member “who even contended that the failure to  
 7 include that language on the EOB impacted their ability to get an independent medical review.”  
 8 (*Cignarale Tr. 23969:7-12, Zaretsky Tr. 18993:7-11, 18995:8-12, Kessler Tr. 20879:7-16*)

9 488. Requests for IMRs were in fact being made prior to inclusion of notice of IMR  
 10 rights on PacifiCare’s form EOBs. (*Campbell Tr. 5837:19-5838:14; Exh. 5201*)

11 489. There was no increase in the number of IMRs requested following the addition of  
 12 IMR language in PacifiCare’s EOBs, even accounting for declining membership. (*Monk Tr.*  
 13 *8874:5-8876:20, Kessler Tr. 20880:17-20881:14; Exh. 5298, p. 5*)

14 490. From January 2007 to November 2010, PLHIC PPO members requested only 39  
 15 IMR over a 47 month period, during which time PacifiCare processed millions of claims. (*Exh.*  
 16 *5473; Cunningham Tr. 14542:17-14543:11*)

17 491. Applying the same standard that CDI is applying to this proceeding, the number of  
 18 non-compliant forms would be substantially larger during periods of prior CDI examinations of  
 19 Blue Cross, CIGNA and Aetna, none of which included notice of IMR rights in their form EOBs  
 20 by as late as 2007. (*Exh. 5440; Cignarale Tr. 23373:6-23376:22, 23379:9-23380:4, Stead Tr.*  
 21 *24452:17-24456:12; Exh. 547; Washington Tr. 14742:2-8*)

**CDI Exams of Insurers Whose EOBs Did Not Have Notice of IMR**

Insurer CDI	Claims During Period	Period Months	MCE Cites	Evidence
Blue Cross ‘07	7,572,843	1/04-2/06	0	<a href="#">Exh. 5479*</a>
CIGNA ‘03	2,464,203	4/02-3/03	0	REQ. OFF. NOT., <a href="#">Tab 16</a>
Aetna ‘04	1,326,682	1/03-12/03	0	REQ. OFF. NOT., <a href="#">Tab 32</a>

1 492. If there were significant harm associated with the failure to include IMR language  
2 in an EOB, CDI could be expected to have provided notice to the industry as to CDI's position  
3 on the requirement. (*Stead Tr. 24349:14-24350:7*)

4 493. CDI has never publicly taken the position that the failure to include notice of IMR  
5 rights in every EOB constitutes a violation of Section 790.03. (*Cignarale Tr. 22943:15-21,*  
6 *23016:1-23020:3, Kessler Tr. 22024:10-23*)

7 494. In the final 2007 MCE reports on PLHIC, CDI acknowledged the EOB/IMR issue  
8 as "something other than violations of Section 790.03," despite having a legal obligation to  
9 report any violations of Section 790.03 in the 2007 MCE public report. (*Cignarale Tr. 22837:3-*  
10 *24, 23008:1-10, 23016:1-23018:19, Stead Tr. 24415:25-24417:8*)

11 495. Deputy Commissioner Cignarale conceded that there was "nothing in [the]  
12 confidential report that would have put the company on notice that the Department was  
13 considering contending [absence of IMR language in EOBs to be] violations [of] Section  
14 790.03." (*Cignarale Tr. 22837:3-24, 23008:1-10, 23016:1-23018:19, Stead Tr. 24415:25-*  
15 *24417:8*)

16 496. The 2007 MCE reports and the conclusions therein were approved by CDI senior  
17 management. (*Cignarale Tr. 23010:13-23013:24*)

18 497. The original OSC in this enforcement action did not plead alleged EOB violations  
19 as violations of Section 790.03, and when CDI later purported to amend the Public Report at the  
20 beginning of this enforcement hearing, it did not include these allegedly non-compliant form  
21 EOBs as violations of Section 790.03. (*Cignarale Tr. 23026:25-23028:18; Exhs. 1, 123*)

22 498. PLHIC had a policy of encouraging and facilitating IMRs even in states which do  
23 not require it. (*Ho Tr. 15426:11-25*)

24 **D. Alleged Violations Arising from Failing to Acknowledge the Receipt of**  
25 **Claims (First Amended OSC, ¶¶ 105-111)**

26 499. California [Section 10133.66\(c\)](#) applies to providers and became effective on  
27 January 1, 2006, only six months before commencement of the 2007 MCE Period. (*Monk Tr.*  
28 *8982:24-8983:9*)

1           500. A separate regulation, 10 CCR § 2695.5(e), governs acknowledgment of claims  
2 submitted by members. (*Vandepas Tr. 936:7-12*)

3           501. PLHIC had reasonable processes in place to promptly acknowledge receipt of  
4 claims. (*Berkel Tr. 7681:3-7694:20*)

5           502. PLHIC had a telephone system in place well before enactment of [Section](#)  
6 [10133.66\(c\)](#) that allowed a provider to readily confirm the date on which PLHIC received a  
7 claim. (*Sing Tr. 7171:10-7186:16, 9332:14:-9389:25, Berkel Tr. 7688:2-7690:9, 8015:17-*  
8 *8030:9; Exhs. 5240, 5241, 5242, 5243*)

9           503. PLHIC designed the telephone acknowledgment system to be compliant with the  
10 pre-existing and analogous DMHC regulation (28 CCR § 1300.71). (*Monk Tr. 8974:24-8976:3,*  
11 *9313:8-9316:9; Exh. 5326*) The Legislature intended to model [Section 10133.66\(c\)](#) after the  
12 DMHC regulation and the two laws are substantially identical in relevant parts. (*Monk Tr.*  
13 *8974:24-8976:3, 9313:8-9316:9; Exhs. 5326, 5679*)

14           504. The telephone acknowledgment system is staffed by customer service  
15 representatives (“CSRs”) trained to inform providers the “received” “date” for a claim in  
16 “response to a general claims status inquiry” whether or not providers specifically request that  
17 information. (*Sing Tr. 7192:18-7195:19*)

18           505. PLHIC witnesses demonstrated through the use of training materials that it was  
19 PLHIC’s express policy to train its CSRs to look up and provide the received date of a claim  
20 when responding to general inquiries concerning claims status. (*Sing Tr. 7193:11-7196:18,*  
21 *Murphy Tr. 13562:17-13564:11; Exh. 5244*)

22           506. PLHIC makes its provider customer service number readily available, and has used  
23 the same number since 2000. (*Exhs. 5135, 5240, 5241; Sing Tr. 7172:12-7174:7, Berkel Tr.*  
24 *7688:2-7689:8*)

25           507. Even if a provider calls the wrong PacifiCare customer service number, the  
26 telephone acknowledgment system is designed to route providers to the right number. (*Sing Tr.*  
27 *9332:23-9333:14*)

28

1           508. Providers are in fact aware and utilize the telephone acknowledgment system to  
2 check on the status of a claim or claims; PLHIC demonstrated that providers regularly called to  
3 ask about the “status of the claim,” or “[if] the claim [had] been received.” (*Bigam Tr.*  
4 *14951:11-14953:12, Berkel Tr. 7690:13-7692:7, Murphy Tr. 13565:10-13566:1; Exh. 5243*)

5           509. PLHIC demonstrated that providers utilized PLHIC’s phone systems to access  
6 information on claims with evidence that it received over 150,000 inquiries in 2006 and 2007  
7 concerning claims status, which rebuts CDI’s speculation that providers did not know how to call  
8 PLHIC to obtain claims status information. (*Sing Tr. 7184:4-7186:16; Exh. 5243*)

9           510. The administrative burden from using the telephone system to check on the status  
10 of a claim is minimal. The wait time to speak with a CSR averaged less than 60 seconds during  
11 2006, 2007 and 2008 and total call time averaged between five and six minutes. (*Sing Tr.*  
12 *9335:19-9336:14, 9341:22-9342:18*)

13           511. Post-Merger, PacifiCare implemented a robust quality program that audits CSRs to  
14 ensure accurate information is provided to callers about the status of claims, including the correct  
15 date of receipt. (*Exh. 5245; Sing Tr. 7197:3-18, 7200:4-7201:25*)

16           512. DMHC confirmed to PacifiCare that a telephone system whereby a provider can  
17 call to obtain acknowledgment of receipt of a claim complies with the DMHC regulation. (*Exh.*  
18 *5263; Berkel Tr. 7676:1-25, Monk Tr. 12402:4-12405:15, 12419:23-12420:19, 12434:5-*  
19 *12442:3*)

20           513. DMHC did not cite PacifiCare of California for any violations for failing to  
21 acknowledge claims in its investigation and examination. (*David Tr. 11623:2-5*)

22           514. CDI did not undertake any effort to determine if PLHIC’s telephone customer  
23 service system complied with Section 10133.66(c). (*David Tr. 11568:11-15, Vandepas Tr.*  
24 *973:10-16*)

25           515. PLHIC also established a system that automatically acknowledged any claims that  
26 are submitted electronically. (*Berkel Tr. 7680:14-7687:14; Exh. 5147, p. L-7*)

27  
28

1           516. To the extent that PacifiCare had an obligation to send provider acknowledgment  
2 letters for paper claims, its failure to do so was inadvertent. (*Stead Tr. 24350:14-22, 24352:10-*  
3 *24353:14, 24472:10-23, Berkel Tr. 11195:11-1196:11*)

4           517. Notice of CDI’s position that health insurers are required to send to providers  
5 written acknowledgment letters for paper claims was essential given the fact that the DMHC had  
6 a similar regulation to [Section 10133.66\(c\)](#) and that DMHC considered use of a telephone system  
7 to be compliant with its regulation. (*Kessler Tr. 20898:7-20900:13, Stead Tr. 25625:10-*  
8 *25627:9; Exh. 5708, p. 19*)

9           518. CDI had never initiated “an enforcement proceeding before PacifiCare where the  
10 Department took [the] position with a licensed entity under its jurisdiction” that a health insurer  
11 is required to acknowledge receipt of paper claims in writing or that the failure to do so  
12 constituted an unfair business practice. (*Kessler Tr. 20898:2-20900:13, 20991:3-20992:6,*  
13 *Cignarale Tr. 22833:1-22834:7, 22835:23-22837:17, Stead Tr. 24257:13-18, 24337:19-*  
14 *24340:15, 24350:8-24357:20; Exh. 5622; Vandepas Tr. 958:4-10, Laucher Tr. 13333:4-7*)

15           519. CDI’s position in this proceeding with regard to acknowledgment letters is “not  
16 based in the statute,” but some unwritten policy within the Department. (*David Tr. 11637:1-17*)

17           520. No written bulletin, guideline or manual supports CDI’s interpretation that an  
18 insurer must send an acknowledgment letter on a paper claim. (*Vandepas Tr. 973:17-974:4,*  
19 *David Tr. 11572:8-20, 11634:5-24, Cignarale Tr. 23661:19-25*)

20           521. CDI staff gave conflicting testimony about whether written acknowledgment letters  
21 were required for paper claims under [Section 10133.66\(c\)](#):

- 22           a. Ms. Vandepas agreed that a telephone system such as PacifiCare’s 1-800 line was  
23 compliant “[a]s long as they could identify that the claim has been received and the  
24 date of receipt of claim could be identified.” (*Vandepas Tr. 1000:25-1002:4*);
- 25           b. Mr. Dixon claimed that the statute allowed for acknowledgment via a website, but  
26 “that the insurance company has to go to the provider’s web site and acknowledge  
27 the claim,” which is a position no other CDI witness or PacifiCare has taken in this  
28 proceeding. (*Dixon Tr. 5318:25-5320:15*);

1 c. Ms. David agreed that if the “Company utilizes alternative methods like a  
2 telephone or website,” an “[acknowledgment] letter would not be required.” (*David*  
3 *Tr. 11564:10-11569:20*).

4 522. CDI management never trained its staff on SB 367 and 634. (*Dixon Tr. 5318:4-24,*  
5 *Laucher Tr. 13093:12-13095:9*)

6 523. CDI could have notified PacifiCare and the rest of the industry of its interpretation  
7 of [Section 10133.66\(c\)](#) if it had wanted to do so. (*See, e.g., bulletins issued by CDI for*  
8 *interpretations of other insurance laws - Exhs. 5624, 5648, 5656, 5708 (pp. 5-6), 5709;*  
9 *Cignarale Tr. 23067:5-22, 23070:6-23071:4, Stead Tr. 24254:9-24260:24*)

10 524. Both CDI and PacifiCare demonstrated a significant amount of confusion over  
11 [Section 10133.66\(c\)](#) and its application. (*Stead Tr. 24472:10-24474:9, 25119:23-25120:17,*  
12 *25198:4-13*)

13 525. In the 2007 MCE, CDI initially concluded that there was an acknowledgment letter  
14 violation in every claim file even though claims that were paid within 15 working days or  
15 processed through an electronic clearinghouse (EDI) did not require written acknowledgment  
16 letters. (*Washington Tr. 9612:21-9613:20*)

17 526. CDI asserted in the 2007 MCE report that its “[e]lectronic data analysis also  
18 detected that the Company did not comply with acknowledgment of claims receipt,” but during  
19 the hearing, CDI admitted that was a false statement, when CDI’s Derek Washington, who  
20 performed the electronic analysis of PacifiCare’s claims data, admitted that he did not “conduct  
21 [the claims acknowledgment] analysis because the data [was] not sufficient.” (*Washington Tr.*  
22 *9569:21-9571:10, David Tr. 11573:1-11574:23*)

23 527. In its draft and final 2007 MCE reports, CDI incorrectly referred to a standard of 15  
24 calendar days as opposed to 15 working days for acknowledging paper claims from providers.  
25 (*Exhs. 1, 116 (Final Confidential Report, p. 19)*)

26 528. PacifiCare initially accepted CDI’s contention at face value that the law required  
27 PacifiCare to send acknowledgment letters on paper claims. (*Berkel Tr. 7671:16-7672:8,*  
28 *11195:11-11196:11, 11279:20-24, Monk Tr. 8987:15-8988:19, 12424:12-12425:18*)

1           529. PacifiCare mistakenly believed that it was sending provider acknowledgment  
2 letters during part of the 2007 MCE period and failed to subtract from the totals it reported to  
3 CDI in the Berkel December 7, 2007 letters claims processed through an electronic  
4 clearinghouse, which do not require written acknowledgment letters. (*Berkel Tr. 7686:3-12,*  
5 *7706:19-7708:7, 10101:9-10102:15, 10106:13-22, Monk Tr. 12442:13-12443:7*)

6           530. PacifiCare clarified any prior confusion about its processes “with respect to both  
7 member and provider claim acknowledgment letters in a face-to-face meeting in March of 2008.”  
8 (*Monk Tr. 8990:18-8996:7, Berkel Tr. 7696:24-7697:2, Cignarale Tr. 23827:14-23833:21*)

9           531. PLHIC also committed to complete and did complete in the time promised, a series  
10 of corrective actions that included a process for sending written acknowledgment letters for  
11 paper claims not paid within 15 calendar days, a process for imaging and storing any  
12 acknowledgment letters that the company sends, focused audits and weekly reports to ensure that  
13 letters were being sent. (*Berkel Tr. 10116:9-10117:12, 10134:4-16, 11197:2-23*)

14           532. Assuming that acknowledgment letters were in fact required, PLHIC had a general  
15 business practice of acknowledging claims within the 15 working day statutory period. (*Stead*  
16 *Tr. 24426:14-24428:16*)

17           533. Approximately 95% of claims during the 2007 MCE Period received some form of  
18 written acknowledgment within 15 working days from receipt of the claim. (*Dixon Tr. 5281:3-*  
19 *5282:11, Berkel Tr. 7692:24-7697:2; Exhs. 5057, 5243*)

20           534. This 95% compliance rate is within the acceptable tolerance threshold set forth in  
21 the NAIC Handbook. (*Exh. 876*)

22           535. Prior to May 2010, CDI had never publicly taken the position that the failure to  
23 send providers written acknowledgment letters for paper claims pursuant to [Section 10133.66\(c\)](#)  
24 constituted a violation of Section 790.03. (*Exh. 597; Kaiser Permanente Public Report,*  
25 *5/24/2010; Standard Insurance Company Public Report, 10/25/2010; Cignarale Tr. 22835:12-*  
26 *22836:6, 22837:3-17*)

27           536. In the final 2007 MCE reports on PacifiCare, CDI acknowledged the alleged  
28 violations of [Section 10133.66\(c\)](#) as “something other than violations of Section 790.03,” despite

1 having a legal obligation to report any violations of Section 790.03 in the 2007 MCE public  
2 report. (*Exhs. 1, 5296; David Tr. 11583:10-11584:5, Laucher Tr. 13285:1-7*)

3 537. Indeed, [Section 10133.66\(c\)](#) was implemented substantially after Section 790.03  
4 and does not refer to Section 790.03 or the associated regulations under 10 CCR sections 2695,  
5 et seq.

6 538. The 2007 MCE reports and the conclusions therein were approved by CDI senior  
7 management. (*Cignarale Tr. 23010:13-23013:24*)

8 539. Deputy Commissioner Cignarale conceded that there was “nothing in [the]  
9 confidential report that would have put the company on notice that the Department was  
10 considering contending [failure to send providers written acknowledgment letters] violations [of]  
11 Section 790.03.” (*Cignarale Tr. 22837:3-24, 23008:1-10, 23016:1-23018:19, 24415:25-*  
12 *24417:8*)

13 540. The original OSC in this enforcement action did not plead alleged claims  
14 acknowledgment letter violations as violations of Section 790.03. And when CDI later purported  
15 to amend the Public Report at the beginning of this enforcement hearing, it did not allege these  
16 violations to be violations of Section 790.03. (*Cignarale Tr. 23025:12-23026:18; Exhs. 1, 123*)

17 541. PacifiCare’s failure to send provider acknowledgment letters for paper claims was  
18 inadvertent, and constituted, at most, a single act in violation of [Section 10133.66\(c\)](#). (*Stead Tr.*  
19 *24350:14-22, 24352:10-24353:14, Berkel Tr. 11195:11-11196:11*)

20 542. CDI’s approach to counting the number of alleged violations of [Section](#)  
21 [10133.66\(c\)](#) is inconsistent with CDI’s approach in other MCEs and enforcement actions.  
22 (*Cignarale Tr. 22832:16-22836:6; Exhs. 5424, 5425*)

23 543. Since the PLHIC exam, CDI has charged only two other insurers for failing to  
24 timely acknowledge claims pursuant to [Section 10133.66\(c\)](#) and 790.03. In those two  
25 examinations, CDI cited only the number of violations in the sample reviewed and not the entire  
26 population of claims even though the insurer admitted that it had not been in compliance with the  
27 statute or regulation. CDI did not bring an enforcement action against either of those insurers.  
28

1 (Kaiser Permanente Public Report, 5/24/2010, Standard Insurance Company Public Report,  
2 10/25/2010)

3 544. There is no evidence that any provider was harmed by failing to receive a written  
4 acknowledgment letter in connection with its submission of a claim, and CDI has no record of  
5 “any provider having ever complained that PacifiCare was not” sending claims acknowledgment  
6 letters. (*Dixon Tr. 5316:5-5318:3, Laucher Tr. 13218:12-13226:16, Smith Tr. 223:23-224:12,*  
7 *Black Tr. 1353:18-1355:2, Ho Tr. 15429:5-15430:12, Kessler Tr. 20882:17-20886:2; Exh.*  
8 *5622)*

9 545. CMA, a sponsor of SB 634, “never raised any concerns with regard to  
10 acknowledgment[.]” of claims in its complaints about PacifiCare to CDI or DMHC. (*Black Tr.*  
11 *1353:18-25)*

12 546. No provider complained or testified in this proceeding about failing to receive a  
13 written acknowledgment letter or not being able to determine the received date of a claim.  
14 (*Dixon Tr. 5317:12-5318:3, Harvey Tr. 11784:16-19, Ho Tr. 15429:5-15430:12, Wetzel Tr.*  
15 *16939:20-16940:4)*

16 547. In fact, many providers do not want acknowledgment letters sent to them and  
17 actually complained once the Company implemented a letter process that “it was a lot of mail  
18 junking up their mailbox.” (*Harvey Tr. 11784:20-25, Berkel Tr. 7698:7-21, 10169:9-10170:19,*  
19 *Monk Tr. 8968:20-8969:3, Bigam Tr. 14953:13-14954:12, 14963:7-14965:16, Ho Tr. 15429:5-*  
20 *15430:12)*

21 548. Receiving and dealing with form acknowledgment letters creates an administrative  
22 burden on providers that is greater than picking up the phone to call. (*Bigam Tr. 14953:13-*  
23 *14954:12, Cignarale Tr. 23235:4-12)*

24 549. CDI failed to demonstrate that the administrative burden on providers was greater  
25 where an insurer fails to send written acknowledgment letters. (*Cignarale Tr. 23489:4-23490:1,*  
26 *23564:2-23569:13, 23948:24-23959:7, Zaretsky Tr. 18975:5-18985:5)*

27  
28

1           **E. Alleged Violations Arising from Failing to Timely Pay Claims (First**  
2           **Amended OSC, ¶¶ 99-102)**

3           550. Insurers have an incentive to pay claims timely in California. (*Berkel Tr. 7433:9-*  
4           *7434:13)*

5           551. Employer groups and individuals use timeliness as a measure in deciding which  
6           insurer to use. (*Berkel Tr. 7433:24-7434:4)*

7           552. Further, the interest on late paid claims typically exceeds an insurer’s rate of return  
8           and/or an insurer’s time value of money. (*Berkel Tr. 7434:5-7435:10, Kessler Tr. 20886:15-*  
9           *20887:22)*

10          553. Nevertheless, insurers always have some percentage of late pays. (*Vonderhaar Tr.*  
11          *6333:18-23, 6336:7-16, 6987:6-10, Berkel Tr. 7780:23-7781:10, 10024:13-21, Laucher Tr.*  
12          *14157:12-16, Cignarale Tr. 23041:19-23042:11)*

13          554. As a result, CDI has historically established tolerance thresholds around claim  
14          payment timeliness in a number of circumstances. (*Exhs. 5191, 5292, 5671; Cignarale Tr.*  
15          *23777:5-23795:17; see also Findings 232-242.*

16          555. In 2005, CDI established tolerance thresholds around certain claims-handling  
17          metrics (including timeliness) in the Undertakings that were designed to be “reflective of  
18          PLHIC’s historic performance.” (*Monk Tr. 8755:10-8756:12, 12545:4-12557:3; Exh. 5191)*

19          556. PacifiCare adopted a number of policies and procedures related to the prompt  
20          investigation and processing of claims. (*Berkel Tr. 7438:21-7439:22, 7782:5-16, Norket Tr.*  
21          *3525:5-3528:8)*

22          557. For example, shortly after the Merger, PacifiCare adopted United’s internal  
23          timeliness standards for the processing of claims that were stricter than those required by law,  
24          setting a standard for payment of 96.5% of claims within 10 working days and 98 percent of  
25          claims within 20 working days. (*Norket Tr. 3525:5-3528:8, Vonderhaar Tr. 6798:8-6800:24,*  
26          *Berkel Tr. 7435:16-7436:12)*

1           558. PacifiCare also adopted United’s more robust quality control standards around  
2 claims processing that included regular audits, bonuses, feedback and PacifiCare-PPO dedicated  
3 auditors. (*Berkel Tr. 7438:18-7446:13, Goosens Tr. 7249:5-7254:20; Exh. 607*)

4           559. In connection with the 2007 MCE, CDI detected non-compliance in less than 4% of  
5 the total paid claims population involved in the 2007 MCE. (*Exh. 5190; Dixon Tr. 5300:5-  
6 5303:23, Berkel Tr. 7657:12-19*)

7           560. PacifiCare’s general business practice during the 2007 MCE Period was to pay  
8 claims within the statutorily required time period. (*Berkel Tr. 7783:11-7785:16, Stead Tr.  
9 25235:4-25236:17*)

10           561. PacifiCare also met or exceeded the standard for timeliness set by CDI in the  
11 Undertakings, which were expressly incorporated by reference into CDI’s order approving the  
12 Merger between PacifiCare and United. (*Monk Tr. 8764:25-8765:20, 12545:4-12561:15, Berkel  
13 Tr. 7436:19-7438:1, 10024:15-21, Kessler Tr. 20900:14-20901:16; Pleading No. 71 (Monk  
14 Declaration); Exhs. 5615, 5621, p.7, 5634; Cignarale Tr. 22787:14-18*)

15           562. Deputy Commissioner Cignarale admits that the “Department [does not] dispute  
16 that PLHIC has complied with the metrics in Undertaking 19 identified” for claims payment  
17 timeliness. (*Cignarale Tr. 22787:14-18, Monk Tr. 8767:9-12*)

18           563. It is unreasonable for CDI to contend that conduct that exceeds a CDI mandated  
19 performance metric subjects PacifiCare to a finding that it engaged in an unfair business practice.  
20 (*Kessler Tr. 20901:1-19*)

21           564. PacifiCare also met or exceeded the tolerance thresholds set forth in the NAIC  
22 Handbook. (*Exh. 876*)

23           565. During the 2007 MCE Period, PLHIC paid 99.3 % of its claims within thirty  
24 working days. (*Berkel Tr. 7437:14-7438:17*)

25           566. [Section 10123.13\(a\)](#) contemplates that some number of claims will be paid after 30  
26 working days, and provides a remedy in the event that occurs.

27  
28

1 a. PacifiCare complied with [Section 10123.13](#) in 99.5% of the claims at issue by  
2 either paying the claim timely, or paying interest on the claim. (*Berkel Tr.*  
3 [7647:18-7648:5; Exh. 5252, p. 11](#))

4 567. Front end issues (*e.g.*, Lason, UFE, installation and verification of eligibility) did  
5 not have a material impact on the timeliness of PacifiCare’s claims processing. (*Vonderhaar Tr.*  
6 [6154:16-6156:12, 6343:3-10, 6796:3-6798:22, Berkel Tr. 7784:3-7785:16, 11182:9-13](#))

7 568. Self-initiated reworks were the largest contributor to late pays during the MCE  
8 Period. (*Berkel Tr. 11180:12-23*)

9 569. There are a number of irregularities around CDI’s process for calculating late pays  
10 in this proceeding.

11 570. CDI used an electronic analysis to determine the number of alleged late pays even  
12 though using such an analysis was not its standard practice, particularly for an examination of  
13 more than one million claims. (*Stead Tr. 24774:25-24775:11*)

14 a. Derek Washington, CDI’s staff member responsible for the electronic analysis.  
15 spent only seven hours in total conducting that analysis. (*Washington Tr. 9593:14-*  
16 [9595:7](#))

17 b. CDI reported in the 2007 MCE reports that its late pays analysis was based on the  
18 electronic analysis, when in fact it was not. (*See Exh. 1 at pp. 6, 39; David Tr.*  
19 [11560:9-11562:11](#))

20 571. CDI lowered the number of calendar days that correspond to 30 working days  
21 (from 45 days to 42 days) in the midst of the 2007 exam, resulting in thousands more alleged late  
22 pays. (*Exh. 5190; David Tr. 11548:2-11550:25; Exhs. 5331, 5382*)

23 a. CDI used a 42 calendar day standard with PLHIC even though it typically applies a  
24 standard of 45 calendar days in market conduct exams, “because it’s based upon 30  
25 working days.” (*Washington Tr. 9578:17-9579:2*)

26 572. By its own admission, CDI’s reported figure for PacifiCare’s late pays was 20%  
27 higher than it should have been. (*Exh. 1177 - Fourth Supplemental Accusation, ¶¶ 23, 25*  
28 *(withdrawing 7, 203 claims)*)

- 1 a. CDI's errors included double counting overpayment recoveries which "should not
- 2 have been included in the number of late pays." (*Washington Tr. 9603:16-*
- 3 *9604:13, Berkel Tr. 7639:4-7640:22, 10043:9-24; Exhs. 107, 5252, p. 6923*)
- 4 b. PLHIC notified CDI at the time of the 2007 MCE that CDI was erroneously
- 5 including overpayment recoveries as late pays. (*Exh. 107; Washington Tr.*
- 6 *9573:13-9575:5, 9604:6-13, David Tr. 11516:5-11519:2*)
- 7 c. CDI's staff member with healthcare expertise concluded that late pays do not
- 8 include claims where the amount owed applies against a member's deductible.
- 9 (*David Tr. 11519:14-11520:22; Exh. 5381*) Nevertheless, CDI continues to charge
- 10 those claims as claims payment timeliness violations.

11 573. The incidence of late pays in this enforcement action does not exceed what is

12 typically experienced by health insurers in the state. (*Berkel Tr. 7657:8-7558:7, 10024:13-21,*

13 *Monk Tr. 12545:4-12557:3, Stead Tr. 25849:11-25850:9, 25258:20-25259:23*)

14 574. CDI staff testified that they have seen worse cases of non-compliant behavior

15 involving late pays. (*Dixon Tr. 5308:5-15*)

16 575. PLHIC has paid interest on all late paid claims at the statutory rate of 10%. (*Berkel*

17 *Tr. 11182:14-11183:16; Exh. 5252*)

18 576. In the final 2007 MCE reports on PacifiCare, CDI acknowledged that PacifiCare's

19 alleged non-compliance with the late pay statute as "something other than violations of Section

20 790.03," despite having a legal obligation to report any violations of Section 790.03 in the public

21 MCE report. (*Laucher Tr. 13284:12-25, Cignarale Tr. 22837:3-10, 23008:1-10, 23016:12-*

22 *20318:19, Stead Tr. 24415:25-24417:8*)

23 577. Those 2007 MCE reports and the conclusions therein were approved by CDI's

24 senior management. (*Cignarale Tr. 23010:9-23013:24; Exh. 5655*)

25 578. The original OSC did not plead the alleged violations around late paid claims as

26 violations of Section 790.03, and when CDI later purported to amend the Public Report at the

27 beginning of this enforcement hearing, it did not include these alleged violations to be violations

28 of Section 790.03. (*Cignarale Tr. 23025:12-23028:18; Exhs. 1, 123*)

1 579. In most instances where CDI has examined claims payment timeliness issues, CDI  
 2 did not cite late paid claims under [Section 10123.13\(a\)](#), but instead only cited instances where  
 3 insurers failed to pay interest on late paid claims under [Section 10123.13\(b\) and \(c\)](#). (See, e.g.,  
 4 *Standard Insurance Company Public Report, October 15, 2010, Union Labor Life Insurance*  
 5 *Company Public Report, July 9, 2010)*

6 580. In several prior instances, CDI determined the total number of untimely paid claims  
 7 in a claims population, yet either cited no untimely claims payment violations or limited the  
 8 alleged violations to the number of claims reviewed in the sample during the examination.

Insured	Untimely Payments	MCE Cites	Penalty Assessed
Time	17,969	0	None
Principal	33,602	0	None
Mega (Midwest)	30,224	131	\$200,000
American Home Shield	11,438	0	None
Kaiser Permanente	66,264	0	None
New York Life	7,490	3	None

(Req. Off. Not. Tabs 12, 13, 18, 19, 24, 33)

15 581. In several prior instances, CDI has published the frequency of untimely claims  
 16 payments relative to the total number of claims but only assessed a penalty of \$200,000 in one  
 17 such case even though the insurer had paid 20% of its claims after 30 working days, as compared  
 18 to PLHIC, which paid less than 3% of its claims after 30 working days.

Insurer	Untimely Payments	Total Claims	Untimely %	MCE Cites	Penalty Assessed
Time	17,969	100,692	17.85%	0	\$0
Mega (Midwest)	30,224	148,019	20.42%	131	\$200,000

(Req. Off. Not. Tabs 12, 24)

22 **F. Alleged Violations Arising from Failing to Pay Interest on Late-Paid**  
 23 **Claims (First Amended OSC, ¶¶ 103-104)**

24 582. Prior to, and during the relevant time period for these charged violations,  
 25 PacifiCare had in place policies and procedures to pay statutory interest on any claim paid after  
 26 30 working days. (Exh. 117, Att. 29)

27 583. PLHIC has a policy of paying interest when in doubt. (Berkel Tr. 7653:22-7654:5,  
 28 7773:15-7774:21; Exh. 5252)

1 584. PLHIC failed to timely pay interest in connection with 5,196 claims, totaling  
2 \$142,101.01. (*Berkel Tr. 7648:8-18, 11182:14-11183:16; Exhs. 730, 777, 5252, 5369*)

3 585. The root cause for PLHIC’s failure to timely pay interest on these claims was  
4 “human error.” (*Berkel Tr. 7648:23-7649:8*)

5 586. The median interest due on these 5,196 claims was \$0.87. (*Berkel Tr. 11188:11-*  
6 *17; Exhs. 781, 5369, p.4, 5720*)

7 587. PLHIC remediated the problem and implemented a series of corrective actions  
8 designed to minimize error associated with the payment of interest, including development of a  
9 software program for calculating interest, additional training, and focused audits. (*Vonderhaar*  
10 *Tr. 6851:5-6852:21, 6965:25-6967:2, Berkel Tr. 7649:9-7653:17; Exhs. 355, 357, 5252, 117,*  
11 *Att. 51*)

12 588. Prior to this hearing, CDI provided no notice that the failure to pay interest under  
13 [Section 10123.13\(b\)](#) constituted a defined unfair business practice under Section 790.03. To the  
14 contrary, in one instance, CDI filed a pleading seeking an administrative determination under  
15 Section 790.06 that the failure to pay interest on a late benefit payments constituted an unfair  
16 business practice under Section 790.03. CDI would not have sought such recourse under 790.06  
17 if the failure to pay interest was already defined, or considered by CDI, to be an unfair business  
18 practice under 790.03 (*Exh. 5669*)

19 589. In the final 2007 MCE reports on PacifiCare, CDI categorized PacifiCare’s alleged  
20 non-compliance with the interest portion of the late pay statute as “something other than  
21 violations of Section 790.03,” despite having a legal obligation to report any violations of  
22 Section 790.03 in the 2007 MCE public report. (*Exh. 1; Laucher Tr. 13284:12-25, Cignarale Tr.*  
23 *22837:3-10, 23008:1-10, 23016:12-20318:19, Stead Tr. 24415:25-24417:8*)

24 590. Those 2007 MCE reports and the conclusions therein were approved by CDI’s  
25 senior management. (*Cignarale Tr. 23010:9-23013:24; Exh. 5655*)

26 591. The original OSC did not plead the alleged violations around failure to pay interest  
27 on late paid claims as violations of Section 790.03, and when CDI later purported to amend the  
28

1 Public Report at the beginning of this enforcement hearing, it did not include these alleged  
2 violations to be violations of Section 790.03. (*Cignarale Tr. 23025:12-23028:18; Exhs. 1, 123*)

3 **G. Alleged Violations Arising from Incorrectly Denying Claims Based on an**  
4 **Illegal Pre-Existing Condition Exclusionary Period (First Amended OSC,**  
5 **¶¶ 116-118)**

6 592. CDI has challenged denials for only approximately 5,000 claims out of a total of  
7 500,000 denied claims during the 2007 MCE Period. These claims involve PLHIC's application  
8 of an incorrect 12 month pre-existing condition exclusionary period for large group coverage.  
9 (*Exh. 1209, ¶¶ 168-172*)

10 593. PLHIC's application of the incorrect 12 month exclusionary period for large group  
11 coverage was inadvertent. (*Monk Tr. 8906:16-8907-10, 9229:11-9230:1, Stead 25197:14-201:4,*  
12 *Vonderhaar Tr. 6849:24-6850:23*)

13 594. At all times relevant to this proceeding, PLHIC had in place reasonable procedures  
14 and training for applying the pre-existing exclusionary period. (*Exh. 117, Att. 17, Att. 3;*  
15 *PacifiCare October 12, 2007 Response to CDI Referral "Pre-Existing Procedures Group -*  
16 *General Inquiry #2" (9/28/07); Vonderhaar Tr. 6965:7-19*)

17 595. PLHIC mistakenly included the wrong exclusionary period, even though it utilized  
18 personnel with "familiarity with the filing [of regulatory products] and insurance codes in the  
19 states in which [they are] filing documents," and did so with respect to this particular filing.  
20 (*Monk Tr. 8909:5-22, 9217:6-9218:16, 9219:8-9221:20*)

21 596. CDI's own conduct confirms that the mistake was inadvertent. (*Monk Tr. 8909:5-*  
22 *22, 9217:6-9218:16; Exh. 5318*)

23 597. In 2004, CDI approved a Certificate of Coverage with the wrong exclusionary  
24 period (the "Certificate of Coverage"). (*Smith Tr. 211:1-25, Berkel Tr. 11249:18-22, Monk Tr.*  
25 *8904:25-8909:22, 9215:21-9228:4; Exhs. 5299, p. 24, 118, Att. 17*)

26 598. CDI approved subsequent amendments to the Certificate of Coverage without  
27 raising any concern about the length of the exclusionary period. (*Monk Tr. 8908:12-8909:22;*  
28 *Exhs. 5317, 5318*)

1           599. CDI failed to discover any alleged pre-ex exclusionary period issues while  
2 conducting the 2006 Routine Exam. (*Exh. 5181; David Tr. 11430:14-23*)

3           600. No one at CDI ever complained that PLHIC was using the incorrect exclusionary  
4 period until PLHIC brought the issue to the CDI's attention. (*Smith Tr. 211:13-25, 220:2-  
5 222:4, Berkel Tr. 7511:19-7512:11*)

6           601. PLHIC staff disclosed the issue to CDI in Fall 2006 when Ms. Hulbert raised  
7 concerns about whether PLHIC was using the proper exclusionary period. (*Smith Tr. 221:7-  
8 222:4, Berkel Tr. 7511:19-7512:11, 9979:8-9980:23; Exh. 559*)

9           602. After confirming with CDI staff that PLHIC was in fact applying the incorrect  
10 period, PLHIC modified the policy to properly reflect the correct exclusionary period and  
11 notified its members and brokers of the error and changes. (*Monk Tr. 8910:4-15, Smith Tr.  
12 245:11-246:20, 265:17-267:4, Berkel Tr. 7575:4-7576:2; Exhs. 740, 5018, 5260*)

13           603. PLHIC began the process of re-working affected claims in December 2006 and  
14 payments were being made as claims were reworked. (*Exhs. 559, 601, 5257; Berkel Tr.  
15 7512:12-7513:22, 10224:17-10225:19, Monk Tr. 8910:16-20*)

16           604. PLHIC completed the rework project of the claims at issue in this proceeding by  
17 April 4, 2007 prior to receiving notice of the 2007 MCE. (*Exh. 601; Smith Tr. 248:18-249:1,  
18 Cignarale Tr. 23102:8-19, Berkel Tr. 10224:17-10225:12*)

19           605. PLHIC committed to engage in and did in fact engage in a series of focused audits  
20 designed to monitor its performance in its application of the correct exclusionary period. (*Berkel  
21 Tr. 10229:11-10230:10, 10234:9-22; Exhs. 6, 70, p. 1409, 741*)

22           606. With respect to PLHIC's re-processing of claims affected by the application of the  
23 incorrect pre-ex exclusionary period, Nicoleta Smith was mistaken when she suggested that  
24 claims submitted by affected members subsequent to the reworked pre-ex claims also had to be  
25 re-processed to properly apply the member's deductible. (*Stead Tr. 24966:15-24969:5; Exh. 15*)

26           607. When reprocessing claims, the company applies the amount of deductible  
27 remaining, if any for that year, at the time of reprocessing, not at the time the claim was  
28 originally adjudicated. (*Exh. 15*)

1           608. CDI has not presented “any evidence to support [the contention] that the company  
2 improperly applied the deductible” when it reworked these affected claims. (*Smith Tr. 258:18-*  
3 *260:4*)

4           609. For each claim reprocessed due to the incorrect pre-ex exclusionary period, the  
5 company sent the affected member a letter explaining the issue and inviting the member or  
6 provider to contact the company or CDI if the member or provider believed the claim had still  
7 been incorrectly processed. (*Exh. 5017*) No record exists of even one complaint of that nature  
8 being made.

9           610. The financial impact associated with remediating the claims at issue in this  
10 proceeding totaled \$765,157. (*Smith Tr. 250:3-11, Dixon Tr. 4734:8-20; Exhs. 601, 5016, 5165*)

11           611. CDI has not presented any evidence of harm to members beyond the claims impact  
12 caused by the denial of claims, which PLHIC remediated. (*Stead Tr. 24465:5-24466:21; Exh.*  
13 *5707*)

14           612. CDI has not presented any evidence that any member affected by the 6 vs. 12  
15 month exclusionary period issue was dissuaded from seeking medical care. (*Berkel Tr.*  
16 *10231:13-10233:1*)

17           613. CDI did not identify “even one member whose medical condition suffered as a  
18 result of the denials at issue around the pre-ex issues,” nor did CDI “actually look and see  
19 whether any members were adversely affected medically as a result of these pre-ex denials.”  
20 (*Cignarale Tr. 23490:2-23494:21*)

21           614. In the context of settlement discussions, CDI’s Andrea Rosen asked PLHIC to  
22 waive application of its pre-existing exclusion provision prospectively for any remaining PLHIC  
23 members. (*Berkel Tr. 10241:6-10242:6, Cignarale Tr. 23096:14-23101:15*)

24           615. Deputy Commissioner Cignarale was not aware of the “Department ever [having]  
25 asked another health insurer to waive the pre-ex exclusion.” (*Cignarale Tr. 23101:12-15*)

26           616. Because completely waiving the pre-ex exclusion “would put [PLHIC] at a  
27 competitive disadvantage to all of the other California carriers that have that same provision,”  
28

1 PLHIC executives “offered to Ms. Rosen [a ‘compromise position’] as a middle ground,” but she  
2 “rejected it.” (*Berkel Tr. 10241:6-10245:2; Exh. 741*)

**Ex. 742**

3 617. CDI has not presented any evidence linking PLHIC’s use of the claims processing  
4 vendor MedPlans to the incorrect processing of claims based upon a 12 month exclusionary  
5 period.

6 618. CDI’s claims and proposed findings of fact related to PLHIC’s allegedly inaccurate  
7 application of the pre-existing condition exclusion are not relevant to any claims at issue in this  
8 proceeding. The Court dismissed these allegations from this proceeding on March 21, 2012 and  
9 re-confirmed on August 9, 2012 that they will not be included in any part of its Proposed  
10 Decision because PLHIC did not have an adequate opportunity to defend against the allegations.  
11 (*March 21, 2012 Hearing Tr. 25713:13-25722:12, August 9, 2012 Hearing Tr. 26249:22-*  
12 *26250:21, 26263:1-3*)

13 **H. Alleged Violations Arising from Incorrectly Denying Claims Due to**  
14 **Failing to Maintain Certificates of Creditable Coverage (First Amended**  
15 **OSC, ¶¶ 119-122)**

16 619. Health insurers often include a provision in their policies which excludes coverage  
17 for a pre-existing condition, unless the member can present evidence of prior continuous  
18 coverage. (*Smith Tr. 59:3-61:1*)

19 620. To avoid application of the pre-existing conditions exclusion, new members must  
20 present the insurer with a certificate of creditable coverage or “COCC” from their prior health  
21 plan evidencing prior coverage. (*Smith Tr. 59:3-61:4; <[http://www.insurance.ca.gov/0100-](http://www.insurance.ca.gov/0100-consumers/0070-health-issues/health-insurance-terms.cfm)*  
22 *consumers/0070-health-issues/health-insurance-terms.cfm*>)

23 621. Health insurers, such as PacifiCare, rely on members and their employer groups to  
24 provide COCCs when a new member is enrolled with the Plan. (*Mace-Meador Tr. 1595:17-24*)

25 622. Prior to the Merger, PacifiCare employed a manual process to sort and route the  
26 COCCs to its claims system upon receipt. (*Berkel Tr. 8088:5-8089:25, 8094:14-25*) PacifiCare  
27 would then note the existence of a COCC in its claims systems. (*Berkel Tr. 8094:14-25*)  
28

1           623. PacifiCare experienced issues with regard to handling and routing of incoming  
2 COCCs prior to the Merger. (*Sing Tr. 3362:13-3363:7, Berkel Tr. 11250:15-18*)

3           624. After the Merger, as part of the transition of mailroom intake and routing functions  
4 to Lason, the company spent significant resources and time developing an automated system to  
5 image, route and track non-claims incoming mail (which PLHIC calls “correspondence”),  
6 including COCCs. (*Murray Tr. 13682:3-13683:13, 13712:14-13714:20*)

7           625. As part of the redesign of PacifiCare’s legacy mail routing process during the  
8 Lason transition, attention was paid to addressing pre-Merger problems experienced with  
9 COCCs, including “being clearer in the mail sorting,” “making sure someone knew the DocDNA  
10 queue for certificates of credible coverage,” and “making sure that, if that person was out,  
11 somebody else knew they had the role of dealing with the inventory that day.” (*Berkel Tr.*  
12 *7456:24-7458:12, Murray Tr. 3200:4-24, 13709:11-13713:5, 13729:17-13730:15*)

13           626. PacifiCare had planned and begun the process of transitioning to an automated mail  
14 distribution system using an outside vendor “prior to the acquisition even being announced.”  
15 (*Murray Tr. 3164:20-3166:13, Vavra Tr. 13886:3-25*)

16           627. As can be expected when transitioning from a manual to automated process, the  
17 company experienced certain challenges with that transition, and implemented a series of  
18 improvements over time to address those issues. (*Murray Tr. 3200:4-3201:21, 3204:3-3208:8,*  
19 *13726:4-13727:8, McNabb Tr. 19831:14-13832:2*)

20           628. CDI and PacifiCare staff began discussing concerns CDI had with regard to the  
21 alleged mishandling of COCCs in early December 2006. At that time, PacifiCare put together a  
22 corrective action plan and team to implement it. (*Exh. 5720; S. Hulbert email to N. Smith*))

23           629. PacifiCare’s corrective action team was made up of members from “Claims,  
24 Customer Care, Appeals, MAS [Membership Accounting Services]” in order to “address  
25 [COCCs] across departments.” PacifiCare created a number of process improvements in  
26 connection with remediating issues surrounding its handling of COCCs. (*Sing Tr. 3362:13-*  
27 *3364:14, Vonderhaar Tr. 6361:25-6362:14, Berkel Tr. 7562:25-7563:18; Exh. 348*)

28

1           630. CDI contends that the Lason transition impacted PacifiCare’s handling of COCCs  
2 because staff had difficulty searching for such documents while they were en route to their  
3 intended destination. However, prior to the Lason transition, there was no way to search for  
4 documents that were being manually routed in inter-office envelopes.

5           631. When the DocDNA electronic routing program was launched as part of the Lason  
6 transition, PacifiCare staff were initially unable to search paper mail that was being  
7 electronically routed using a member’s ID number because this search functionality was not built  
8 into the system at the time.

9           632. When Sue Berkel requested that the ability to search for documents by member ID  
10 be added to DocDNA, senior management approved Ms. Berkel’s request for this functionality,  
11 as well as every other operational improvement requested by her that potentially impacted  
12 compliance. (*Berkel Tr. 8086:10-19, 8290:8-14, 11306:16-19*)

13           633. The fact that Ms. Berkel was initially told that the search by member ID  
14 functionality was “not in the budget” is irrelevant given PLHIC’s decision to fund it.

15           634. Even before searching by member ID was available, users could search DocDNA  
16 queues for specific documents, including COCCs, using the claim number or Document Control  
17 Number. (*Berkel Tr. 8087:18-21, Murray Tr. 3619:24-3620:9*)

18           635. CDI has not identified one person whose medical condition suffered as a result of  
19 PacifiCare’s alleged mishandling of COCCs. (*Cignarale Tr. 23490:2-11, 23492:15-23493:12*)

20           636. CDI has not quantified what, if any, problems with COCCs resulted from  
21 PacifiCare’s outsourcing of mailroom functions to Lason. (*Cignarale Tr. 22889:6-22892:22*)

22           637. CDI failed to present evidence of the extent of harm associated with the  
23 mishandling of COCCs, or even the number of claims impacted as a result of any alleged  
24 mishandling. (*Cignarale Tr. 23493:4-23494:21, Kessler Tr. 21173:15-21174:8, 21179:12-*  
25 *21180:12*)

26           638. Though CDI contends that there was an “influx” of consumer complaints about  
27 COCCs in the Fall of 2006, in fact, CDI reviewed “a few complaints” involving COCC issues,  
28

1 and “vastly overstated” the financial impact from such issues. (*Laucher Tr. 13055:15-21; Exhs.*  
2 *5009, 5019, 5165*)

3 639. Out of 130 CDI complaint closure letters from March 2006 to January 2009, only  
4 nine involved alleged mishandling of COCCs. (*Exhs. 22, 29, 40, 41, 76, 79, 166, 182, 209*)

5 640. CDI failed to present any evidence that PLHIC committed any violations of law  
6 relating to the handling of COCCs. While CDI relies on *Exh. 5016* to support its assertion that  
7 1,799 claims were impacted by alleged mishandling of COCCs, that document, incorrectly  
8 labeled “Updated Listing of COCC claims that have been reprocessed,” relates solely to re-  
9 processing of claims from 2006 applying the incorrect 12 month pre-ex exclusionary period, a  
10 separately charged violation. (*Exh. 5016; Berkel Tr. 7562:25-7563:18*)

11 641. PLHIC demonstrated that the 1,799 claims CDI now characterizes as COCC-  
12 affected claims are in fact claims that were initially denied for an incorrect pre-ex exclusionary  
13 period:

- 14 a. In April 2007, PLHIC identified to CDI 4,818 “Pre-Ex” or “COCC claims [from  
15 2006] that have been reassessed” as part of the company’s corrective action.
- 16 b. PLHIC explained that 3,019 of those reassessed claims required additional  
17 payments of \$765,157 because they had been denied due to application of the 12  
18 month pre-ex exclusionary period.
- 19 c. The error in CDI’s assumptions around the extent and impact of COCC-related  
20 denials is demonstrated by the fact that CDI asserts the same dollar impact from  
21 alleged COCC issues (\$765,157) as it does for the 3,019 claims that PLHIC  
22 reported for denials associated with its incorrect application of the 12 month pre-ex  
23 exclusionary period. (*CDI Finding 260(a); CDI Brief, p. 116:6-7*)
- 24 d. As to the remaining 1,799 claims out of the 4,818, PLHIC reported that although  
25 they had been denied for application of the 12 month pre-ex exclusionary period,  
26 but “no additional payment” was required after the claims had been reassessed, not  
27 that they were COCC-related denials. (*Smith Tr. 255:17-23*)

1 e. CDI’s Nicoleta Smith concurred with PLHIC that “the 1799 [in [Exh. 5016](#)] ties to  
2 the number that [she identified] as claims that the company reworked” on pre-ex  
3 issues. ([Smith Tr. 254:11-14, 255:17-23](#); see also [Exh. 103](#) “*Corrected Count of*  
4 *Reworked Pre-Ex Claims*)

5 642. Whether characterized as COCC-related or as pre-ex claims based on an incorrect  
6 exclusionary period, the company remediated all of the affected claims ([Cignarale Tr. 23102:8-](#)  
7 [15](#)), and CDI never expressed concern about the sufficiency of remediation for any of these  
8 claims. ([Cignarale Tr. 23103:9-13](#))

9 643. CDI concluded that mishandling of COCCs did not constitute a general business  
10 practice of the company. ([Cignarale Tr. 22841:5-12](#))

11 **I. Alleged Violations Arising from Failing to Correctly Pay Claims (First**  
12 **Amended OSC, ¶¶ 166-167)**

13 644. CDI alleges 3,700 violations based on PLHIC “unreasonably delay[ing] the  
14 uploading of provider contracts, resulting in incorrect claims payments.” ([Second Supp.](#)  
15 [Accusation, Ex. 597, ¶ 55](#))

16 645. PLHIC executives provided the 3,700 figure as an estimate of the retroactively  
17 reworked claims associated with termination of access to CTN’s network. ([CDI Prop. FOF, ¶](#)  
18 [501; McFann Tr. 2212:12-15](#))

19 646. At trial, PLHIC updated this estimate to eliminate any duplication and concluded  
20 that the total impact from the CTN termination was 2,662 claims. ([Exh. 5252, p. 6929](#))

21 647. The claims impact was relatively minimal: 2,662 claims out of 1,735,029 total  
22 claims processed and \$89,191 of additional payments out of hundreds of millions of claim  
23 dollars paid. ([Exhs. 549, 5217, 5252, p. 6929](#))

24 648. The delays associated with negotiating and uploading provider contracts were  
25 reasonable under the circumstances since the claims impact resulted from a one-time  
26 unprecedented event, i.e., CTN’s termination of access to its network. ([Berkel Tr. 7398:11-](#)  
27 [7399:9, McFann Tr. 12952:24-12953:16](#))

28

1           649. PacifiCare and United dedicated substantial resources to timely address issues  
2 created by the CTN termination, including re-allocating hundreds of employees from across the  
3 enterprise to assist in California in re-contracting, streamlining the process to generate a  
4 negotiated contract, and designing and implementing new fee schedule templates to expedite the  
5 contract loading process. (*McFann Tr. 10663:6-10664:3, 10693:19-10696:1; Exh. 5341*)

6           650. The contract loading process would not have benefited from adding additional  
7 personnel to load contracts because new personnel would have required extensive training and  
8 familiarity with the contract loading systems. (*Berkel Tr. 7393:18-7394:9*)

9           651. PLHIC processed the claims at issue correctly based on the existing information in  
10 RIMS. (*Berkel Tr. 7398:11-7399:9*)

11           652. When re-contracting with providers, insurers routinely experience some claims  
12 rework from contracts loaded after the effective date. (*Berkel Tr. 7398:11-7399:9, 9747:2-9,*  
13 *McFann Tr. 10672:4-7, 12958:5-20*)

14           653. During this period, providers contributed to contracts being loaded after the  
15 effective date by, among other things, (1) delaying negotiations to increase leverage, (2)  
16 submitting contracts with incomplete information that had to be returned, (3) executing contracts  
17 after the effective date, and (4) failing to honor commitments to hold claims until PacifiCare had  
18 a reasonable time to load the contract. (*McFann Tr. 10672:8-18, 10673:5-10674:12, 10675:22-*  
19 *10677:15*)

20           654. In many of these instances, the providers nevertheless insisted that PacifiCare apply  
21 the contracts retroactively and re-work claims submitted prior to execution of the contract.

22           655. CDI failed to offer any proof with regard to what percentage of the claims at issue  
23 resulted from some wrongful conduct by PLHIC.

24           656. There is no evidence in the record that PLHIC had a general business practice of  
25 untimely loading provider contracts.

26           657. To the extent CDI attempts to argue that any penalty that may be imposed for this  
27 category of alleged violations should be enhanced on the basis of approximately 78,000  
28 allegations, the Court has determined that any such allegations will not form part of its Proposed

1 Decision because PLHIC did not have an adequate opportunity to defend against the allegations.  
2 (*March 21, 2012 Hearing Tr. 25713:13-25722:12, August 9, 2012 Hearing Tr. 26249:22-*  
3 *26250:21, 26263:1-3*)

4 1. Alleged Violations Arising from Failing to Correctly Pay Claims Submitted by  
5 UCSF (First Amended OSC, ¶¶ 155-160)

6 658. The Court dismissed these alleged violations from this proceeding on March 21,  
7 2012 and re-confirmed on August 9, 2012 that they will not be included in any Proposed  
8 Decision. (*March 21, 2012 Hearing Tr. 25713:13-25722:12, August 9, 2012 Hearing Tr.*  
9 *26249:22-26250:21, 26263:1-3*)

10 2. Alleged Violations Arising from Failing to Correctly Pay Claims Submitted by  
11 UCLA (First Amended OSC, ¶¶ 161-163)

12 659. The Court dismissed these alleged violations from this proceeding on March 21,  
13 2012 and re-confirmed on August 9, 2012 that they will not be included in any Proposed  
14 Decision. (*March 21, 2012 Hearing Tr. 25713:13-25722:12, August 9, 2012 Hearing Tr.*  
15 *26249:22-26250:21, 26263:1-3*)

16 3. Alleged Violations Arising from Failing to Respond to Claims Submitted by  
17 UCLA (First Amended OSC, ¶¶ 164-165)

18 660. The Court dismissed these alleged violations from this proceeding on March 21,  
19 2012 and re-confirmed on August 9, 2012 that they will not be included in any Proposed  
20 Decision. (*March 21, 2012 Hearing Tr. 25713:13-25722:12, August 9, 2012 Hearing Tr.*  
21 *26249:22-26250:21, 26263:1-3*)

22 **J. Alleged Violations Arising from Improper and Untimely Overpayment**  
23 **Demands to Providers (First Amended OSC, ¶¶ 141-148)**

24 661. CDI contends that PLHIC sent 1,934 “first request” letters to providers requesting  
25 return of claim overpayments more than 365 days after the date the claim had been paid, contrary  
26 to Insurance Code § 10133.66(b).

27 662. Insurance Code § 10133.66(b) became effective January 1, 2006, and contains no  
28 language indicating that it is to be given retroactive effect.

1           663. PLHIC had in place written policies and procedures for collecting overpayments,  
2 including limiting to 365 days the “# of days PHS has to identify the overpayment from payment  
3 date.” (*Exh. 381, p. 3357*)

4           664. PLHIC’s policies and procedures show that PLHIC’s general practice was to issue  
5 timely first request letters and to enter into its Overpayment Database information about the date  
6 the first request letter was sent. (*Exh. 381, pp. 3357, 3365-3366; Bugiel Tr. 6642:16-6643:23,*  
7 *11901:14-11902:1*)

8           665. In early 2008, PLHIC instructed Johnson & Rountree Premium (“J&R”), a vendor  
9 providing overpayment recovery services, to issue “second request” letters to payees listed in  
10 PLHIC’s Overpayment Database with amounts remaining owing. (*Cassady Tr. 2957:13-2958:1,*  
11 *2972:2-9, Bugiel Tr. 6649:19-24, 6667:7-22*)

12           666. At the time PLHIC instructed J&R to issue second request letters, PLHIC  
13 understood that timely first request letters had already been sent. (*Bugiel Tr. 3752:25-3753:15,*  
14 *3763:19-3764:9, 3767:4-9, 6719:23-6720:3, 6722:19-24; Exh. 381*)

15           667. In early 2008, after issuing the OSC, CDI asked PLHIC to provide information  
16 about overpayment collection efforts after receiving complaints from CMA on behalf of a few  
17 providers. (*Exhs. 592, 739, p. 3646; Berkel Tr. 10217:23-10219:18, Bugiel Tr. 6715:2-5*)

18           668. In response to CDI’s inquiries, PLHIC suspended J&R’s collection efforts and  
19 ultimately waived recovery of approximately \$1.4 million in connection with 2,912 overpayment  
20 recovery requests. (*Exh. 589; Bugiel Tr. 6708:24-6709:18, 11890:1-11891:13, McFann Tr.*  
21 *10723:9-10724:06*)

22           669. In hindsight, PLHIC abandoned collection efforts on a number of valid  
23 overpayment recoveries, resulting in significant monetary losses to PLHIC and a windfall for the  
24 providers who retained those overpayments.

25           670. As the record of the hearing and CDI’s First Amended OSC demonstrates, CDI is  
26 only alleging that, there were 1,934 instances where improper overpayment recoveries were  
27 attempted.

28

- 1 a. CDI initially attempted to increase the number of alleged violations from 2,912 to  
2 4,831 allegedly based on data produced in connection with this hearing. (*Exh. 597*,  
3 ¶¶ 59-62)
- 4 b. PLHIC presented evidence that in at least 2,693 instances either a timely first  
5 request letters was subsequently located, the provider had voluntarily refunded the  
6 overpayment, or no effort had been made to collect the overpayment (i.e., no letter  
7 was sent). (*Bugiel Tr. 11893:18-11894:14, 11896:9-11898:9; Exh. 5392*)
- 8 c. Of the remaining 2,138 claims, PLHIC presented evidence that 204 letters related  
9 to PacifiCare Life and Assurance Company (PLAC), resulting in at most, 1,934  
10 alleged violations. (*Bugiel Tr. 11898:12-22, 11896:15-19; Exh. 5392*)

11 671. Of the 1,934 alleged violations, 223 letters relate to recoveries sought in connection  
12 with Medicare claims, for which PLHIC is allowed two years to initiate recovery efforts. (*Bugiel*  
13 *Tr. 12728:22-12729:24*)

14 672. As reflected in the testimony of Brian Bugiel, the legacy PacifiCare imaging  
15 system used to retain first request letters is no longer in use, and utilizes aged technology that  
16 makes it difficult to reliably establish whether all letters have been retrieved. (*Bugiel Tr.*  
17 *11914:13-11923:5, 12720:1-12727:6*)

18 673. Given the limitations on the ability of PLHIC to reliably establish whether all  
19 letters have been retrieved, it is unreasonable to infer that PLHIC had not sent a first request  
20 letter within 365 days of payment if one was not found.

- 21 1. Alleged Violations Arising from Failing to Maintain Complete Claim Files  
22 (relating to overpayment demands) (*First Amended OSC, ¶¶ 149-154*)

23 674. The Court dismissed these alleged violations from this proceeding on March 21,  
24 2012 and re-confirmed on August 9, 2012 that they will not be included in any Proposed  
25 Decision. (*March 21, 2012 Hearing Tr. 25713:13-25722:12, August 9, 2012 Hearing Tr.*  
26 *26249:22-26250:21, 26263:1-3*)

1           **K. Alleged Violations Arising from Closing Or Denying Claims When**  
2           **Requesting Additional Information (First Amended OSC, ¶¶ 168-172)**

3           675. PLHIC’s policy when receiving a claim that requires proof of prior insurance  
4 coverage, or other information necessary to process a claim that is generally within the member  
5 or employer group’s knowledge (such as the existence of secondary insurance), is to close or  
6 deny the claim and indicate with a remark code on the EOB the reason for the company’s  
7 decision and request the necessary information be provided. (See *Berkel Tr. 8090:18-8091: 11*,  
8 *Norket Tr. 2385:8-14, 2362:18-25*) Upon receipt of the requested information, PLHIC then  
9 processes the claim. (*Berkel Tr. 8092:12-17*)

10           676. CDI contends that PLHIC should not have closed or denied claims when it  
11 requested additional information, but rather, contends that PLHIC should have contested the  
12 claims.

13           677. CDI does not present any witness testimony, or identify any regulation or standards  
14 to assess whether PLHIC was required to contest a claim when it requested additional  
15 information. (See *CDI Brief at pp. 250-255* and *CDI Proposed Findings 602 to 628*)

16           678. CDI’s proffered evidence is insufficient to demonstrate that PLHIC acted  
17 inappropriately when it closed or denied claims when requesting additional information.

18           679. CDI alleges one general violation against PLHIC for what it contends is the “illegal  
19 practice” of closing or denying claims when requesting additional information. As described  
20 above in *Finding 677* above, CDI has not identified any standard to assess PLHIC’s practice or  
21 adjudge it to be an “illegal practice.”

22           680. For forty-three of the alleged violations, CDI’s proof is based exclusively on  
23 *Exhibit 127*, a CDI-generated list of randomly sampled claims files. CDI’s reliance on *Exhibit*  
24 *127* is improper and contrary to this Court’s ruling that it was not being admitted “for the proof  
25 of any matter,” and CDI counsel’s representation that “[w]e’re not asking [Your Honor] to make  
26 any findings based on it.” (*Strumwasser Tr. 2833:3-7*)

27           681. For twelve other alleged violations, CDI’s evidence consists of EOBs containing  
28 the remark codes “px” (which indicated that a claim was being denied due to lack of required

1 information) or “iq” (which indicated that a claim was being closed due to the lack of a response  
2 to a prior request for information). (*Exhs. 23, 24, 30, 35, and 128 (pp. 5095, 5096, 5097, 5098,*  
3 *5100, 5109 and 5125)*)

4 a. For four of these twelve alleged violations, CDI relies solely on the EOBs and did  
5 not present any witness testimony or documentary evidence to explain the  
6 circumstances under which they were issued. (*Exhs. 23, 24, 30, 35*)

7 b. CDI failed to meet its burden of proof as to these four alleged violations because no  
8 finding can be based solely on the EOBs without additional evidence concerning  
9 the specific circumstances under which they were issued.

10 682. Seven alleged violations contained in EOBs are found in Exhibit 128, which relates  
11 to Mrs. W’s disputes with PLHIC.

12 a. CDI adduced testimony concerning only one of seven EOBs identified by CDI in  
13 support of the charged violations. (*Exh. 128, p. 5098; Mrs. W Tr. 1016:23-*  
14 *1017:24, 1018:7-1019:1*) CDI counsel did not ask Mrs. W any questions  
15 concerning the other six EOBs cited in support of this charged violation.

16 b. Four of the seven EOBs in *Exh. 128 (pp. 5095 – 5098)* concerned PLHIC’s request  
17 for information concerning other available insurance to enable coordination of  
18 benefits. Such information is typically provided by a member upon enrollment,  
19 and PLHIC’s request for such information was appropriate.

20 c. Concurrent with the EOBs indicating such information was required, on December  
21 15, 2005, PLHIC also sent Mrs. W a letter requesting information concerning any  
22 other insurance coverage her family had at the time. (*Exh. 128, p. 5094*) Mrs. W  
23 did not verbally respond to PLHIC’s inquiry until January 3, 2006, and did not fax  
24 in written confirmation of secondary insurance until January 13, 2006. (*Mrs. W Tr.*  
25 *1019:11-1020:6*)

26 d. A fifth EOB (*p. 5100*) also requesting information concerning other available  
27 insurance was issued one day later on January 4, 2006. Given the passage of time  
28

1 between PLHIC's inquiry and Mrs. W's response, PLHIC's January 4, 2006 EOB  
2 indicating that information was still outstanding was appropriate.

- 3 e. A sixth EOB (p. 5109) concerned PLHIC's January 12, 2006 request in an EOB for  
4 a certificate of creditable coverage (COCC), which Mrs. W testified she faxed to  
5 PLHIC on January 13, 2006. (*Mrs. W Tr. 1020:1-6*)
- 6 f. PLHIC's initial request on January 12, 2006 for a COCC was appropriate, as Mrs.  
7 W's family were new PacifiCare members as of November 2005, and Mrs. W did  
8 not testify to having provided PLHIC with such information upon enrollment.
- 9 g. Mrs. W was told on January 13, 2006 that it would take fifteen to thirty days to  
10 process her COCC into the system, or at the earliest, January 28, 2006. (*Mrs. W Tr.*  
11 *1026:17-19*) Nevertheless, Mrs. W continued to fax PLHIC copies of her COCC  
12 on January 20, 24 and 25, 2006, and she admitted the COCC issue was resolved by  
13 the end of January, as PLHIC had initially represented to her. (*Mrs. W Tr. 1026:3-*  
14 *1027:20*)
- 15 h. The seventh EOB also requesting a COCC was sent on January 20, 2006, only a  
16 week after Mrs. W had initially sent in a copy of her COCC. Given PLHIC's  
17 representation to Mrs. W that it would take 15 to 30 days to process the new  
18 COCC, this request was appropriate under the circumstances.

19 683. For two additional alleged violations, CDI's sole proof consists of two closure  
20 letters issued by CDI to PLHIC on April 4 and 5, 2007. (*Exhs. 40, 41*)

21 684. These closure letters contain conclusory statements that PLHIC committed one or  
22 more violations, do not attach any documentary evidence of the underlying allegations, do not  
23 provide the necessary details by which a reasonable trier of fact could assess the charged  
24 violations, and did not provide PLHIC with an opportunity to contest its findings, in all instances  
25 stating "[n]o response to this letter is required." (*See, e.g., Exhs. 40, 41*)

26 685. The closure letters are administrative hearsay that cannot form the basis for a  
27 factual finding without other competent evidence, which CDI failed to submit. (*Govt. Code §*  
28 *11513(d)*). By themselves, the closure letters do not prove the charged violations.

1           686. CDI did not present any testimony or documentary evidence that PLHIC’s practice  
2 of closing or denying claims when requesting additional information resulted in any financial  
3 impact.

4           a. Specifically as to Mrs. W, she testified that the issues concerning PLHIC’s request  
5 for information concerning her son’s other insurer, Blue Cross, and her family’s  
6 COCC issues were resolved in January. (*Mrs. W Tr. 1025:5-1027:20*)

7           b. Although CDI suggests that EOBs using the “px” and “iq” remark codes are  
8 potentially confusing, Mrs. W, the only member to testify on the issue, indicated no  
9 such confusion when asked what the remark codes meant, and responded that  
10 PLHIC was “requesting to find out if we had secondary insurance or other  
11 secondary insurance in force at the time.” (*Mrs. W Tr. 1017:5-12; Exh. 128 at p.*  
12 *5098*)

13           687. CDI did not provide PLHIC with any notice that PLHIC’s practice of closing or  
14 denying a claim when requesting additional information constituted an unfair practice under  
15 Section 790.03.

16           688. CDI did not charge these fifty-eight allegations as violations of Section 790.03 in  
17 the 2007 MCE reports or the initial OSC.

18           **L. Alleged Violations Arising from Failing To Maintain Complete Claim**  
19           **Files (First Amended OSC, ¶ 114)**

20           689. CDI contends that, in fourteen instances, PLHIC failed to maintain complete claim  
21 files.

22           690. As support for six of its contentions, CDI relies solely on closure letters its  
23 compliance officers send to PLHIC when closing an inquiry made by a member or provider.  
24 These closure letters contain conclusory statements that PLHIC committed one or more  
25 violations, do not attach any documentary evidence of the underlying allegations, do not provide  
26 the necessary details by which a reasonable trier of fact could assess the charged violation, and  
27 did not provide PLHIC with an opportunity to contest its findings, in all instances stating “[n]o  
28 response to this letter is required.” (*See, e.g., Exh. 38, 41, 133*)

1           691. The closure letters are administrative hearsay that cannot form the basis for a  
2 factual finding without other competent evidence, which CDI failed to submit. (*Govt. Code §*  
3 *11513(d)*) By themselves, the closure letters do not prove the charged violations.

4           692. The evidence for the remaining eight alleged violations consisted of findings from  
5 the 2007 MCE report. The reports do not provide sufficient information on which to base a  
6 finding as to PLHIC’s practice regarding maintaining its claims files.

7           693. In view of the large number of PLHIC claim files reviewed by CDI during the 2007  
8 MCE and in the normal course of compliance officer inquiries, the small number of instances in  
9 which CDI contends PLHIC failed to maintain complete claim files supports a finding that it is  
10 PLHIC’s general practice to maintain complete claim files, and CDI does not present any  
11 evidence suggesting otherwise.

12           694. CDI did not present any testimony as to the alleged impact or harm, if any, that  
13 resulted from these alleged violations.

14           **M. Alleged Violations Arising from Failing To Conduct A Thorough**  
15           **Investigation**

16           695. CDI contends that, in 52 instances, PLHIC failed to conduct a thorough  
17 investigation of claims.

18           696. For these 37 of these alleged violations, CDI did not introduce testimony or the  
19 underlying documents, such as the claimant’s communication or PLHIC’s response, to create a  
20 record as to the adequacy of PLHIC’s investigation. Rather, CDI relies solely on closure letters  
21 its compliance officers send to PLHIC when closing an inquiry made by a member or provider.  
22 These closure letters are administrative hearsay and by themselves do not prove the charged  
23 violations.

24           697. PLHIC witnesses presented extensive testimony and documentary evidence  
25 concerning the Company’s policies and procedures around claims processing, including  
26 conducting any requisite investigation prior to taking action on a claim.

27           698. During the period encompassed by these allegations (January 2006 to December  
28 2007), PLHIC processed approximately 2,689,832 claims. (*Exh. 549*) In this proceeding, CDI

1 identifies only 52 instances (the 37 identified with respect to these individual complaints and 15  
2 additional violations relating to Mrs. W and Mr. R, *see Findings 778, et seq., and 791, et seq.*)  
3 where PLHIC allegedly failed to conduct a thorough investigation. This supports a conclusion  
4 that it was PLHIC's general business practice to conduct a thorough investigation of claims.

5 699. CDI did not allege any violations for purportedly failing to conduct a thorough  
6 investigation of claims in the 2007 MCE reports or in CDI's OSC. And when CDI later  
7 purported to amend the Public Report at the beginning of this enforcement hearing, it also did  
8 not allege the failure to conduct a thorough investigation to be a violation of Section 790.03.  
9 *(Cignarale Tr. 23026:19-23028:18; Exhs. 1, 116, 123)*

10 **N. Alleged Violations Arising from Failing to Conduct Business In**  
11 **Company's Own Name**

12 700. CDI contends that PLHIC failed to conduct business in its own name as required by  
13 Insurance Code Section 880 in twenty-nine instances by failing to use the legal name PLHIC on  
14 EOBs and on its letterhead.

15 701. As to PLHIC's EOBs, the Court finds that all of the versions of such documents  
16 admitted into evidence in this proceeding identify "PacifiCare® Life and Health Insurance  
17 Company" in two places on the first page, and CDI has not presented any EOB that states  
18 otherwise. *(See, e.g., Exhs. 25, 26)*

19 702. The only issue that CDI has with respect to the EOBs is that PLHIC did not write  
20 "Underwritten by PacifiCare Life and Health Insurance Company" on them.

21 703. The Court does not find that PLHIC's omission of the term "underwritten by"  
22 violates Section 880, nor is it an unfair business practice under Section 790.03. In any event, to  
23 meet CDI's expectations, PLHIC added an additional phrase "underwritten by PacifiCare Life  
24 and Health Insurance Company" to its EOBs on June 8, 2007. *(Exh. 5314)*

25 704. As to PLHIC's letterhead, which identified the company as "PacifiCare," no  
26 members or providers testified that they were confused or misled by the letters.

27 705. The Court does not find that PLHIC's use of the name "PacifiCare" on its  
28 letterhead violates Section 880, nor is it an unfair business practice under Section 790.03.

1           706. As to each alleged violation, CDI relies solely on closure letters its compliance  
2 officers send to PLHIC when closing an inquiry made by a member or provider. As  
3 administrative hearsay, the closure letters by themselves are not competent proof of the charged  
4 violations.

5           707. Prior to this hearing, CDI provided no notice to PacifiCare that the failure to place  
6 the PLHIC name on its EOBs or letterhead constituted a defined unfair business practice under  
7 Section 790.03.

8           708. In the final 2007 MCE reports, CDI reported the alleged non-compliance around  
9 using the PLHIC legal name on written materials as “something other than violations of Section  
10 790.03,” despite having a legal obligation to report any violations of Section 790.03 in the 2007  
11 MCE public report. (*Cignarale Tr. 22837:3-10, 23008:1-10, 23016:1-23018:19, 24415:25-  
12 24417:8*)

13           709. The 2007 MCE reports and the conclusions therein were approved by CDI’s senior  
14 management. (*Cignarale Tr. 23010:13-23013:24*)

15           710. The original OSC did not plead the alleged violations around use of PLHIC’s legal  
16 name as violations of Section 790.03, and when CDI later purported to amend the Public Report  
17 at the beginning of this enforcement hearing, it did not include the failure to use PLHIC’s full  
18 legal name to be a violation of Section 790.03. (*Cignarale Tr. 23026:19-23028:18; Exhs. 1,  
19 123*)

20           711. CDI did not present any testimony as to any alleged impact or harm that resulted  
21 from these allegations.

22           **O. Alleged Violations Arising from Failing to Train Claims Personnel (First**  
23           **Amended OSC, ¶¶ 123-125)**

24           712. CDI contends that PLHIC failed to provide training in California Fair Claims  
25 Settlement Practices regulations to fourteen PLHIC appeals processors and nine overpayment  
26 recovery processors employed by the overpayment recovery vendor J&R.

27           713. CDI did not present sufficient evidence about the specific functions and duties  
28 performed by appeals processors to demonstrate that their activities come within the definition of

1 a “claims agent” under the regulations, and therefore, CDI has failed to meet its burden of proof  
2 regarding these fourteen alleged violations.

3 714. However, in response to CDI’s inquiry and request, in May 2007, PLHIC provided  
4 such training to its appeals staff. (*Mace-Meador Tr. 1545:17-1546:5*)

5 715. Similarly, CDI did not present sufficient evidence about the specific functions and  
6 duties of J&R’s overpayment recovery processors to demonstrate that their activities come  
7 within the definition of a “claims agent” under the regulations, asserting only that J&R staff have  
8 similar duties to PLHIC appeals staff. (*See Finding 713 above*)

9 CDI did not present any testimony as to the alleged impact, harm or denial of medical care that  
10 resulted from these alleged violations, nor did CDI demonstrate that the any lack of training of  
11 appeals processors or overpayment recovery processors had any adverse impact on the  
12 performance of their duties.

13 **P. Alleged Violations Arising from Failing to Timely Respond to Provider**  
14 **Disputes (First Amended OSC, ¶ 112)**

15 716. Section 10123.137, which became effective January 1, 2006, required insurers to  
16 create and administer a formal PDR process and give providers notice of that right on form  
17 EOPs.

18 717. In compliance with Section 10123.137, PacifiCare created a formal PDR process  
19 and gave notice to providers of that right. (*Exhs. 5046, p. 20-23, 24, p. 3*)

20 718. During the 2007 MCE period, PacifiCare received 16,653 PDR requests, to which  
21 it timely responded within the statutory period 15,143 times (~91%). (*Exh. 5046, p. 22*)

22 719. The evidence thus shows that PLHIC had a general business practice of making  
23 timely responses to PDR requests.

24 720. Also enacted and effective at the same time was the right of providers under  
25 Section 10123.13(a) to seek CDI review of an insurer’s claim adjudication decisions (see  
26 PacifiCare’s findings regarding alleged EOP violations).

27 721. CDI’s internal guidelines mandate that providers seeking CDI review must first  
28 demonstrate that they have pursued the insurer’s formal PDR process. (*Exh. 5085*)

1           722. As a result, with the exception of certain special complainants identified in this  
2 proceeding where CDI waived this requirement (e.g., CMA, Dr. Griffin), a provider complaint  
3 received by CDI would have first proceeded through PacifiCare’s PDR process.

4           723. During the 2007 MCE period and subsequent six months (approximately May 2006  
5 to December 2007), CDI received 158 provider complaints, representing less than 1% of the  
6 PDR requests PacifiCare had received during the MCE period. (*Exh. 5720*)

7           724. Of those 158 provider complaints, approximately 28 of them, or less than 1/5th  
8 were considered justified by CDI, and the remainder were found not to have any merit and/or  
9 were outside CDI’s jurisdiction to resolve. (*Exh. 5622, p. 39*)

10           725. CDI did not present any evidence that providers were harmed by any untimely PDR  
11 responses; to the extent PacifiCare’s initial claims decision was upheld, there was no effect on  
12 the provider’s claim, and if it was overturned, the provider received interest on their claim(s)  
13 dating back to the initial date of receipt of the claim.

14           726. PacifiCare implemented corrective action and improvements to its PDR process  
15 both prior to and after the 2007 MCE, including improved training of staff handling PDRs,  
16 improved correspondence routing procedures to ensure more timely delivery of PDR-related  
17 materials, and focused audits on its PDR handling. (*Berkel Tr. 7774:7-21, 10235:11-17; Exh.*  
18 *376*)

19           727. PLHIC received no notice that untimely PDR responses violated [CIC § 790.03](#).

20           728. In the final 2007 MCE reports for PacifiCare, CDI acknowledged the untimely  
21 PDR issue as “something other than violations of Section 790.03,” despite having a legal  
22 obligation to report any violations of Section 790.03 in the final 2007 MCE public report. (*Exh.*  
23 *116; Cignarale Tr. 22837:3-10; 23016:1-23019:9, Stead Tr. 24416:9-24417:8*)

24           729. Those 2007 MCE reports and the conclusions therein were approved by CDI senior  
25 management. (*Cignarale Tr. 23011:17-23013:24*)

26           730. The original OSC did not plead the alleged violations around untimely PDR  
27 responses as violations of Section 790.03, and when CDI later purported to amend the Public  
28

1 Report at the beginning of this enforcement hearing, it did not include these alleged violations to  
2 be violations of Section 790.03. (*Exhs. 1, 123*)

3 **Q. Alleged Violations Arising from Failing To Timely Respond To CDI**  
4 **Inquiries (First Amended OSC, ¶ 113)**

5 731. CDI contends that PLHIC failed to respond to twenty-nine inquiries from CDI  
6 within twenty-one calendar days from the date PLHIC received the inquiry.

7 732. As support for its contentions, CDI relies solely on closure letters its compliance  
8 officers send to PLHIC when closing an inquiry made by a member or provider. These closure  
9 letters contain conclusory statements that PLHIC committed one or more violations, do not  
10 attach any documentary evidence of the underlying allegations, do not provide the necessary  
11 details by which a reasonable trier of fact could assess the charged violation, and did not provide  
12 PLHIC with an opportunity to contest its findings, in all instances stating “[n]o response to this  
13 letter is required.” (*See, e.g., Exhs. 38, 41, 133*)

14 733. The closure letters are administrative hearsay that cannot form the basis for a  
15 factual finding without other competent evidence, which CDI failed to submit. (*Govt. Code §*  
16 *11513(d)*). By themselves, the closure letters do not prove the charged violations.

17 734. CDI also failed to present any evidence of the date on which PLHIC received any  
18 of these twenty-nine inquiries, a necessary element to any claim of untimely response. In at least  
19 two instances, PLHIC contends that it did not even receive the inquiry, and CDI failed to present  
20 any evidence that PLHIC received these two inquiries. (*Exhs. 133 and 190*)

21 735. As a result of CDI’s failure to establish the date PLHIC received the subject  
22 inquiry, CDI has failed to meet its burden of proof that PLHIC failed to respond timely to the  
23 inquiry from CDI.

24 736. Many of the closure letters also indicate that, although PLHIC responded timely to  
25 CDI’s inquiry, CDI considered the response insufficient because it did not include all documents  
26 CDI expected, and therefore, CDI considered the response to be untimely. (*See, e.g., Exhs. 38,*  
27 *41.*) CDI did not introduce any testimony or the underlying documents, such as its inquiry or  
28

1 PLHIC's response, to permit an assessment of the completeness of PLHIC's response, and thus,  
2 no finding can be made as to the timeliness of PLHIC's response under such circumstances.

3 737. Just as there is no evidence of the date that PLHIC received any of these 29  
4 inquiries, or the circumstances regarding each specific inquiry, CDI failed to present any  
5 evidence that PLHIC knowingly failed to timely respond to CDI with respect to any of these  
6 inquiries.

7 738. Even assuming that CDI's evidence was competent proof of the 29 allegations,  
8 PLHIC received 845 inquiries from CDI for the time period covered by these allegations and  
9 timely responded to over 96% of them. (*Exh. 5720*)

10 739. The evidence shows that it was PLHIC's general business practice to timely  
11 respond to CDI inquiries.

12 740. Other large health insurers had both a greater frequency and a greater number of  
13 untimely responses to CDI inquiries without serious sanction. For example, Anthem Blue Cross  
14 failed to respond timely to 30% of CDI's inquiries from 2006 to 2008 (*Exh. 5663; Cignarale Tr.*  
15 *23394:12-23399:11*); in another enforcement action, CDI charged Blue Shield with 175  
16 untimely responses out of 286 files reviewed, and yet CDI resolved its enforcement matter  
17 against Blue Shield without imposing a monetary penalty. (*Exh. 5418, pp. 11-15; Stead Tr.*  
18 *25794:8-24, 25837:12-16*)

19 741. CDI did not present any testimony as to the alleged impact or harm, if any, that  
20 resulted from these alleged violations.

21 **R. Alleged Violations Arising from Failing To Timely Respond To Claimants**

22 742. CDI contends that, in seven instances, PLHIC failed to provide a complete written  
23 response to a communication from a claimant within fifteen calendar days from the date PLHIC  
24 received the communication. CDI also contends that in two other instances, PLHIC failed to  
25 timely respond to a member appeal within fifteen calendar days.

26 743. CDI did not present sufficient competent documentary or testimonial evidence to  
27 support finding a violations as to the first seven of the nine allegations. For those allegations,  
28 CDI relies solely on closure letters its compliance officers send to PLHIC when closing an

1 inquiry or complaint. These closure letters are administrative hearsay and by themselves, fail to  
2 create a sufficient record for the Court to assess the completeness and timeliness of PLHIC's  
3 response.

4 744. CDI's closure letters do, however, establish that in those seven alleged instances,  
5 the inquiries were made by providers, who are not considered "claimants" under the Fair Claims  
6 Settlement Practices regulations, or CDI's own internal guidelines. (*Exh. 1197; Stead Tr.*  
7 *26131:16-26132:3, 25313:12-25314:17, 25315:19-25316:25*). Therefore, 10 CCR § 2695.5(b)  
8 does not apply to these seven allegations.

9 745. CDI also asserts that for two of the nine allegations, PLHIC's member appeals  
10 department failed to timely respond to a claimant concerning member appeals. (*First Amended*  
11 *OSC, ¶ 185*)

12 a. CDI's evidence to support these two alleged violations consists of (a) a vague, one  
13 page email dated December 19, 2008 (*Exh. 235*), well after the 2007 MCE period,  
14 concerning the results of PLHIC's focused audit as to thirty-five appeals files that  
15 month and (b) a short excerpt of testimony from a PLHIC witness who simply  
16 agreed that the email says what it says and did not otherwise provide any details  
17 regarding the underlying appeals described in the email. (*Mace-Meador Tr.*  
18 *1653:5-12*)

19 b. CDI has failed to meet its burden of proof regarding these two instances, as no  
20 finding can be based solely on the limited and incomplete evidence provided  
21 without any underlying information about the claimant, the date the appeal was  
22 submitted, and the timing, nature and content of any communications and PLHIC's  
23 response(s).

24 746. CDI has also failed to demonstrate that a formal member appeal is a  
25 communication to which PLHIC is required to respond within fifteen calendar days pursuant to  
26 10 CCR § 2695.5(b). PLHIC's standard time for responding to formal member appeals is 30  
27 calendar/working days, a policy and practice PLHIC prominently states on its EOBs, and which  
28 CDI has never criticized. (*Mace-Meador Tr. 1555:17-1556:4; Exh. 140, p. 9740*)

1           747. CDI did not demonstrate that any claimant or member was harmed or denied  
2 medical care as a result of these alleged violations.

3           748. In view of the large number of PLHIC claim files reviewed by CDI during the 2007  
4 MCE and in the normal course of compliance officer inquiries, the small number of instances in  
5 which CDI contends PLHIC failed to timely respond to claimants supports a finding that it is  
6 PLHIC’s general practice to timely respond to claimant inquiries, and CDI does not present any  
7 evidence suggesting otherwise.

8           **S. Alleged Violations Arising from Failing to Record Date that Relevant**  
9           **Documents Are Received, Processed or Transmitted (First Amended OSC,**  
10           **¶ 115)**

11           749. CDI alleges one alleged violation for PLHIC’s alleged “lack of a policy on  
12 recording the date of receipt.” (CDI Brief, p. 296)

13           750. At all times relevant to this proceeding, PacifiCare has had in place processes and  
14 procedures to date-stamp all paper and electronically submitted claims in order “to define the  
15 appropriate received date to be used in Qiclink in order to ensure compliance with regulatory  
16 requirements such as turnaround time (TAT), interest payments and penalties.” (*Exh. 117, p. 3*  
17 (*Att. 29, “QicLink Interest Payment Guidelines”, “Policy No. CL-02-0027.03”; Murray Tr.*  
18 *3600:10-20, 3601:25-3602:8, 13776:8-13777:14, Berkel Tr. 7407:11-7407:13, 7689:25-7690:9,*  
19 *Norket Tr. 2366:2-17, Sing Tr. 7193:21-7195:1; Exhs. 896, 5136, pp. 9899-9900, 5244)*

20           751. PLHIC’s date stamp processes and procedures support the conclusion that it was  
21 PLHIC’s general business practice to accurately record the date of receipt of claims.

22           752. For the four year period following the Merger, PLHIC made quarterly and annual  
23 reports concerning its performance pursuant to Undertaking 19. CDI admits that PLHIC met the  
24 standard for timeliness set forth in Undertaking 19, and never contested the accuracy of PLHIC’s  
25 reports, including the manner in which PLHIC recorded the received date of the claims covered  
26 in those reports. (*Cignarale Tr. 22787:14-18, 23428:22-23429:1, Monk Tr. 8767:5-12, 18067:6-*  
27 *10; Exh. 5286* )

28

1           753. CDI did not present sufficient competent documentary or testimonial evidence  
2 upon which to base a finding that PLHIC failed to implement a policy of recording the date of  
3 receipt of claims.

4           754. CDI did not present any testimony as to the alleged impact or harm, if any, that  
5 resulted from these alleged violations.

6           755. The only evidence CDI cites to support its allegations consists of a single exhibit  
7 (*Exh. 224*), concerning a member appeal and the testimony by Heather Mace-Meador, a Director  
8 in PLHIC's Appeals & Grievances Department, regarding that exhibit.

- 9           a. This evidence does not support CDI's allegation because it merely shows that  
10 PLHIC's member appeals staff did not have, as part of their process for researching  
11 background facts for appeals, an independent procedure for determining the  
12 original receipt date of a claim aside from information available in PLHIC's claims  
13 systems.
- 14           b. The absence of an independent procedure among appeals staff does not support a  
15 finding that PLHIC failed to implement a policy of recording the date of receipt of  
16 claims.
- 17           c. CDI's allegation that PLHIC lacked a process for recording the correct date of  
18 receipt of a claim solely on the basis of *Exhibit 224* is contradicted by extensive  
19 evidence PLHIC presented concerning its policies, processes and training around  
20 recording and using the correct date of receipt of claims. (*See Findings 750 above*)

21           **T. Alleged Violations Arising From Purported Misrepresentations To**  
22           **Claimants Of Pertinent Facts**

23           756. CDI contends that, in 82 instances, PLHIC provided incorrect information to  
24 claimants regarding a claim.

25           757. For these 80 alleged violations, CDI relies solely on closure letters its compliance  
26 officers send to PLHIC when closing an inquiry made by a member or provider. These closure  
27 letters are administrative hearsay and by themselves do not prove the charged violations.

28

1           758. CDI’s closure letters do establish, however, that as to sixty of the allegations, the  
2 communications at issue were between PLHIC and a provider. Providers are not considered  
3 “claimants” under the Fair Claims Settlement Practices regulations or CDI’s own internal  
4 guidelines. (*Exh. 1197; Stead Tr. 26131:16-26132:3, 25313:12-25314:17, 25315:19-25316:25*).  
5 Therefore, 10 CCR § 2695.4(a) does not apply to those sixty allegations.

6           759. CDI did not demonstrate that any claimant was harmed or denied medical care as a  
7 result of these alleged violations.

8           760. In view of the large number of PLHIC claim files reviewed by CDI during the 2007  
9 MCE and in the normal course of compliance officer inquiries, the small number of instances in  
10 which CDI contends PLHIC failed to correctly provide information to claimants supports a  
11 finding that it is PLHIC’s general practice to correctly provide information to claimants, and CDI  
12 does not present any evidence suggesting otherwise.

13           761. CDI also asserts two additional alleged violations for misrepresenting pertinent  
14 facts to claimants arising out of statements allegedly made by PLHIC customer service  
15 representatives (“CSR”) to a member and that member’s employer group benefits representative.

16           762. The single email upon which CDI relies for these two allegations is insufficient, by  
17 itself, to support a finding that a violation occurred. (*Exh. 349*)

- 18           a. In one instance, a member was apparently informed by a PLHIC CSR that he was  
19 covered by PacifiCare’s HMO plan rather than a PPO plan, but this issue was  
20 resolved by the member’s employer group benefits representative that same day.  
21 Nor does it appear that the member was misled by the information, as both he and  
22 his employer group benefits representative knew that he was enrolled in a PPO plan  
23 and were not misled by the information allegedly provided by the CSR. (*Exh. 349*)
- 24           b. The second instance concerned a communication between that same employer  
25 group representative and a PacifiCare broker/employer group specialist, who is not  
26 a CSR in any event. On its face, the email does not reflect that the broker/employer  
27 group specialist misrepresented any pertinent facts concerning whether PLHIC  
28 used real or “dummy” Social Security numbers on member ID cards. Moreover,

1 the email itself does not provide sufficient information for the Court to make a  
2 determination as to whether any misrepresentation occurred.

- 3 c. Also, the employer group’s benefits representative is not a claimant, as that term is  
4 defined under the Fair Claims Settlement Practices regulations. Therefore, 10 CCR  
5 [§ 2695.4\(a\)](#) does not apply to this allegation.

6 **U. Alleged Violations Arising from PLHIC Misrepresentations To CDI**

7 763. CDI’s Opening Brief identifies six separate instances of alleged misrepresentations  
8 but CDI’s proposed findings of fact contain no discussion concerning these allegations.

9 764. The alleged misrepresentations concern one statement about employee turnover and  
10 five statements relating to acknowledgment letters.

11 765. The alleged misrepresentation regarding employee turnover was the alleged failure  
12 to disclose in response to a referral about attrition levels the opinion of one PLHIC claims  
13 manager that employee dissatisfaction with benefits and overtime was the “biggest reason for  
14 turnover.” (*Exh. 363*)

- 15 a. PLHIC witnesses questioned about this exhibit testified that the omitted statement  
16 about employee dissatisfaction with benefits and overtime was not responsive to  
17 the referral. The author of the referral response, Lois Norket, testified that she  
18 “wasn’t really sure if [employee dissatisfaction] was relevant to what we were  
19 really talking about.” PLHIC’s expert Sue Stead did not see “where the Department  
20 has asked for reasons that people have left or the reasons staffing may have  
21 changed,” and the Court itself observed that it “[didn’t] see anything [in Exhibit  
22 363] asking for all the reasons why. They were asking for more general questions.”  
23 (*Norket Tr. 3512:1-3, 3512:21-25, 3513:21-3514:10, Stead Tr. 25109:14-  
24 25113:22*)

- 25 b. Based on CDI’s lack of jurisdiction over, and documented lack of historical interest  
26 in, employee benefits and overtime policies, the omitted information is not  
27 material, and, indeed, is irrelevant to this proceeding, and its omission does not  
28 constitute a misrepresentation by PLHIC.

1           766. As to the five separately alleged misrepresentations concerning PLHIC’s sending  
2 of claims acknowledgment letters, none of PLHIC’s responses on that subject during the 2007  
3 MCE constitutes a misrepresentation of material fact to CDI.

4           767. PLHIC witnesses presented extensive testimony concerning the history of the  
5 Company’s policies and procedures with respect to claims acknowledgment letters, including the  
6 different dates when it sent such letters to members and providers, as well as the reasons why the  
7 Company responded as it did to CDI’s inquiries on this subject during the 2007 MCE.

- 8           a. PLHIC did not make any misrepresentations to CDI concerning its claims  
9 acknowledgment process in Sue Berkel’s December 7, 2007 letter responding to  
10 CDI’s draft confidential report.
- 11           b. Ms. Berkel explained that she prepared the response to CDI’s 2007 draft MCE  
12 report and agreed with its findings without reviewing the language of [Section](#)  
13 [10133.66\(c\)](#) because she was “relying on the Department’s position” that [Section](#)  
14 [10133.66\(c\)](#) required written acknowledgment letters in an effort to “move us  
15 forward, answer what the Department was asking us to do . . . and get to closure on  
16 these issues.” (*Berkel Tr. 7671:16-7672:8*)
- 17           c. Ms. Berkel explained that at the time she “agreed” that PLHIC had violated [Section](#)  
18 [10133.66\(c\)](#) in 81,270 instances, she believed that acknowledgment letters had  
19 been sent for some period of time, but later discovered that she “completely got it  
20 wrong,” and in fact, PLHIC had not been sending written acknowledgment letters  
21 to providers who submitted paper claims. (*Berkel Tr. 7672:9-25*).
- 22           d. Ms. Berkel and her Operations Integrations team discovered in February 2008 that  
23 they and other PLHIC staff had been mistaken about several issues concerning  
24 PLHIC’s compliance with [Section 10133.66\(c\)](#). They discovered that the statute  
25 did not actually require written acknowledgment letters to be sent for paper claims,  
26 that written acknowledgment letters had never been sent previously to providers,  
27 and that member letters had not been sent for some periods of time. (*Berkel Tr.*  
28 [7673:6-20](#))

1 e. Within weeks of discovering their error, Ms. Berkel and Ms. Monk provided a  
2 comprehensive presentation to CDI in March 2008 correcting the information  
3 PLHIC had previously provided. This presentation including the specific dates  
4 when PLHIC was, and was not, sending claims acknowledgment letters to members  
5 and providers. (*Exhs. 817, 5252, pp. 20-25; Berkel Tr. 7694:10-20, Monk Tr.*  
6 *14636:15-14639:5*)

7 768. Ms. Stead concluded that based on her review of the record concerning PLHIC's  
8 communications with CDI concerning claims acknowledgment letters, she did not believe that  
9 PLHIC "misrepresented" or "lied to the regulators." She concluded that:

10 [T]he series of communications there, it tells me that the company was  
11 talking about member letters. There was confusion on their part. There  
12 was similarly confusion on the Department's part about what was really  
13 required by that statute because we saw the Department later changed its  
14 mind about whether letters needed to be sent for each and every claim. So  
15 on both sides, there was this confusion.

16 (*Stead Tr. 24472:10-24474:9, 25118:2-16, 25198:4-13; see also Findings 524, 528-530 re*  
17 *claims acknowledgment*)

18 **V. Specific Member Witnesses**

19 1. Alleged Violations Relating to Mrs. W. (First Amended OSC, ¶¶ 173-178)

20 769. The only regulatory complaint filed by Mrs. W against PLHIC involved requests by  
21 PLHIC for information necessary to process claims that had been submitted for medical services  
22 provided to her son. (*Exh. 128; Brunelle Tr. 805:20-806:11*)

23 770. Ms. W's issues with regard to PLHIC's requests for information regarding her  
24 secondary insurer and COCCs arose prior to the merger and were resolved by the end of January  
25 2006. (*Exhs. 128, p. 5091, 132, p. 4968, 129, p. 5049*)

26 771. At the time Mrs. W filed her complaint against PLHIC with CDI, she  
27 acknowledged that all of the claims payment issues related to her son's treatment had been  
28

1 resolved by PLHIC and she did not seek any claims-payment related relief. (*Exh. 128;*  
2 *Cignarale Tr. 23310:24-23311:5, 23312:19-23314:21*)

3 772. In response to a formal complaint that Mrs. W had filed against Blue Cross, her  
4 son's secondary insurer, for failing to pay claims for her son's medical care, CDI opened a new  
5 complaint on its own initiative against PLHIC on February 27, 2007 without any request from  
6 Mrs. W. CDI justified opening a complaint against PLHIC on the theory that Mrs. W's  
7 complaint against Blue Cross implicated a potential coordination of benefits issue. (*Exh. 5086;*  
8 *Cignarale Tr. 23320:14-20, Brunelle Tr. 1462:17-22*)

9 773. In her 2007 complaint against Blue Cross, Mrs. W complained that Blue Cross  
10 failed to pay its portions of her son's treatments, and that its failure to do so led the providers  
11 treating her son to refuse further treatment. Mrs. W did not allege any wrongdoing by PLHIC  
12 (*Exh. 5086*)

13 774. Mrs. W's son was never denied treatment as a result of any action by PLHIC, but  
14 instead was denied such care because of actions by Blue Cross. (*Exhs. 5086, 5091; Brunelle Tr.*  
15 *1456:18-1457:14, Mace-Meador Tr. 1682:20-1684:25*)

16 775. Ms. W never raised a complaint to CDI that PLHIC had failed to pay any claim.  
17 (*Cignarale Tr. 23313:23-23314:21, 23326:5-19; Exh. 5660*)

18 776. Mrs. W's DMHC complaint against Blue Cross did not allege any wrongdoing by  
19 PacifiCare, who had appropriately paid its share of liability for Mrs. W's son's treatment, a fact  
20 the ALJ observed at trial; "But PacifiCare didn't deny anything. PacifiCare paid what they  
21 believed that they should." (*Exh. 5086; Cignarale Tr. 23317:17-23338:12, 23351:14-23353:21*)

22 777. CDI staff nevertheless cited PacifiCare for 27 alleged violations of the law for form  
23 template violations, even though CDI apparently concluded that it lacked authority to take any  
24 action against Blue Cross because the dispute implicated a contractual dispute. (*Exh. 134; cite to*  
25 *CDI complaint database*)

26 *Specific Allegations Related to Mrs. W in the First Amended OSC*

27 778. Thirteen of the alleged violations relating to Mrs. W that are identified in the First  
28 Amended OSC relate to CDI's contention that PLHIC failed to conduct a thorough investigation

1 of claims before sending Mrs. W written communications or EOBs requesting information from  
2 her in order to process her son's claims.

- 3 a. Six of the thirteen allegations relate to PLHIC's policy of closing claims when  
4 requesting information necessary to process the claim, which PLHIC addresses in  
5 detail at [Findings 682](#) et seq. The evidence presented in connection with those six  
6 alleged violations does not support a finding that PLHIC failed to conduct a  
7 thorough investigation prior to sending Mrs. W the EOBs or committed any unfair  
8 practice.
- 9 b. Two of the thirteen allegations relate to PLHIC's requests for secondary insurance  
10 information from Mrs. W, which PLHIC addresses in detail at [Findings 682 b, c, d](#).  
11 The Court does not find that PLHIC acted improperly or committed any unfair  
12 practice by doing so.
- 13 c. Three of the thirteen allegations relate to PLHIC's alleged requests for COCCs  
14 after Mrs. W claimed to have submitted such proof, which PLHIC addresses in  
15 detail at [Findings 682 e, f, g, h](#). The Court does not find that the evidence supports  
16 a finding that PLHIC acted improperly or committed any unfair practice in acting  
17 as it did.
- 18 d. Two of the thirteen allegations relate to PLHIC's requests for medical records from  
19 Mrs. W. CDI did not present sufficient testimony or documentary evidence to  
20 support a finding that PLHIC conducted an inadequate investigation prior to  
21 making the requests, and therefore, CDI has failed to meet its burden of proof as to  
22 these two allegations.

23 779. CDI also alleges a single violation for failing to maintain a complete claim file  
24 relating to Mrs. W based on PLHIC's denial of a claim on the ground that it had not received a  
25 COCC. As described in [Findings 682 e, f, g, h](#), PLHIC reasonably requested evidence of prior  
26 creditable coverage given that Mrs. W family had enrolled with PLHIC only one month before  
27 her son sought medical treatment.

28

1 780. PLHIC's request for information from Mrs. W related to claims submitted for  
2 medical care already provided to Mrs. W's son, and did not have any impact on his medical care.

3 781. CDI did not demonstrate that Mrs. W or her son suffered any harm as a result of  
4 any alleged violations charged against PLHIC.

5 2. Alleged Violations Related to Mr. R. (First Amended OSC, ¶¶ 179-182)

6 782. In the hearing, Mr. R testified to problems associated with getting reimbursed for  
7 out-of-network eye care services on July 26, 2006. (*Mr. R Tr. 1718:13-22, 1724:14-1725:12;*  
8 *Exh. 135, p. 9886*)

9 783. Mr. R. admitted that he paid the surgeon up front even though he was not required  
10 to do so. (*Mr. R Tr. 1755:16-22*)

11 784. When issues arose with his requests for reimbursement, Mr. R did not pursue  
12 resolution through the appropriate, formal appeals channels, but rather, attempted to resolve the  
13 issues over the telephone. (*Mr. R Tr. 1779:9-1780:1*)

14 785. When he finally pursued an appeal, his issues were resolved within a matter of  
15 days. (*Mr. R Tr. 1758:6-1761:14, 1765:12-17*)

16 786. Had Mr. R. availed himself of PacifiCare's formal appeals process, his issues  
17 would have been resolved earlier. (*Mr. R Tr. 1758:6-1761:16, 1756:12-17*)

18 787. Mr. R received reimbursement from PacifiCare before he ever filed a complaint  
19 with CDI. (*Exh. 5093; Mr. R Tr. 1767:6-1768:9*)

20 788. During his time as a PacifiCare member, Mr. R and his family submitted  
21 approximately 60 claims over a four year period, and he recalled only having problems with the  
22 two claims at issue here. (*Mr. R Tr. 1776:12-1777:6*)

23 Specific Allegations Related to Mr. R in the First Amended OSC

24 789. CDI alleges three violations for misrepresenting pertinent facts to claimants for  
25 issues relating to Mr. R, who claimed that PLHIC made incorrect statements to him concerning  
26 receipt of his claims, and their eligibility for reimbursement.

27 a. In the first instance, Mr. R asserts that PLHIC stated it did not receive a claim for  
28 date of service August 7, 2006 until January 5, 2007. (*Exh. 138, p. 9751*)

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However, Mr. R did not produce any documentary evidence that he actually sent the claim to PLHIC. (*Mr. R Tr. 1762:12-1764:25*)

- b. In the second instance, Mr. R asserts that PLHIC informed him that a claim he submitted for reimbursement was ineligible. However, PLHIC’s statement was correct because Mr. R had failed to provide proof that he had paid the provider on his own. (*Exh. 138, p. 9749*) Once Mr. R. filed a formal appeal with PLHIC and included such proof, PLHIC re-processed and paid the claim. (*Exh. 138, p. 9749; Mr. R Tr. 1760:11-1761:14*)
- c. As to the third instance, PLHIC admitted that it incorrectly denied Mr. R’s second claim due to “examiner error,” and re-processed and paid that claim two days later. (*Exh. 138, p. 9750*)

790. Neither of the three instances described here are misrepresentations of fact. The evidence demonstrates that in two instances, PLHIC acted appropriately based on the facts known to it, and in a third instance, made an error that it corrected. (*See also Findings re Mr. R*)

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791. CDI charges PLHIC with two alleged violations for failing to conduct a thorough investigation of claims arising from two PLHIC requests to Mr. R that he re-submit claims that Mr. R claimed to have previously submitted.

- a. Mr. R did not provide any documentary evidence that he submitted the claims when he claimed to have done so, and admitted that when he subsequently sent the claims to PLHIC at its request, he was paid within the statutory time frame. (*Mr. R Tr. 1762:9-1765:17*)
- b. PLHIC’s requests to Mr. R were made after medical care had been provided and did not have any impact on his medical care.

CDI did not demonstrate that Mr. R suffered any harm or denial of medical care as a result of any alleged violations charged against PLHIC.

Dated: August 31, 2012

SNR DENTON US LLP

By \_\_\_\_\_  
RONALD D. KENT

Attorneys for Respondent  
PACIFICARE LIFE AND HEALTH  
INSURANCE COMPANY

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I, Felix T. Woo, hereby declare:

I am employed in the City of Los Angeles, and am a member of the bar of the State of California. I am over the age of eighteen years and not a party to the within action. My business address is SNR Denton US LLP, 601 South Figueroa Street, Suite 2500, Los Angeles, California 94105.

On August 31, 2012, I served the following:

on the interested parties in this action addressed as follows:

Michael J. Strumwasser Bryce Gee  mstrumwasser@strumwooch.com bgee@strumwooch.com	Mary Ann Schulman  MaryAnn.Schulman@insurance.ca.gov
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**(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 August 31, 2012, at San Francisco, California.

\_\_\_\_\_/s/\_\_\_\_\_  
Felix T. Woo