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A limited liability partnership formed in the State of Delaware

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Inc., UnitedHealthcare, Inc., UnitedHealthcare
11 Insurance Company, UnitedHealthCare
Services, Inc., and UMR, Inc.
12

13 UNITED STATES DISTRICT COURT
14 NORTHERN DISTRICT OF CALIFORNIA
15 SAN FRANCISCO DIVISION
16

17 RACHEL CONDRY, JANCE HOY,
CHRISTINE ENDICOTT, LAURA BISHOP,
18 FELICITY BARBER, and RACHEL CARROLL,
on behalf of themselves and all others similarly
19 situated,

20 Plaintiffs,

21 vs.
22

23 UNITEDHEALTH GROUP INC.,
UNITHEDHEALTHCARE, INC.,
24 UNITHEDHEALTHCARE INSURANCE
COMPANY, UNITHED HEALTHCARE
25 SERVICES, INC., and UMR, INC.,
26

27 Defendants.
28

Case No.: 3:17-cv-00183-VC

DECLARATION OF ABRAHAM J. SOUZA

Honorable Vince Chhabria

I, Abraham J. Souza, hereby declare and state as follows:

1. I am an attorney with Reed Smith LLP, counsel for Defendants UnitedHealth Group Inc., UnitedHealthcare, Inc., UnitedHealthcare Insurance Company, UnitedHealthCare Services, Inc., and UMR, Inc. (collectively, “Defendants”) in this action. I have personal knowledge of the following facts, and if called as a witness, I could and would competently testify to them.

2. Attached hereto as Ex. 1 is a true and correct highlighted copy of the transcript of the January 11, 2019 deposition of Dr. Henry Miller.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on April 16, 2019.

/s/ Abraham J. Souza

Abraham J. Souza

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EXHIBIT 1

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO DIVISION

| | | |
|--------------------------------|---|------------------|
| RACHEL CONDRY, JANCE HOY, |) | |
| CHRISTINE ENDICOTT, LAURA |) | |
| BISHOP, FELICITY BARBER, and |) | |
| RACHEL CARROLL, on behalf of |) | |
| themselves and all others |) | |
| similarly situated, |) | Case No.: |
| |) | 3:17-cv-00183-VC |
| Plaintiffs, |) | |
| |) | |
| vs. |) | |
| |) | |
| UNITEDHEALTH GROUP INC., |) | |
| UNITEDHEALTHCARE, INC.,, |) | |
| UNITEDHEALTHCARE INSURANCE |) | |
| COMPANY, UNITED HEALTHCARE |) | |
| SERVICES, INC., and UMR, INC., |) | |
| |) | |
| Defendants. |) | |
| _____ |) | |

VIDEOTAPED DEPOSITION OF HENRY MILLER, Ph.D.

Phoenix, Arizona
January 11, 2019

Reported by: Helen Pasewark, RPR,
CSR, CCR, CLR, CCRR
Certified Reporter No. 50905

| | |
|---|--|
| <p style="text-align: center;">Page 2</p> <p style="text-align: center;">A P P E A R A N C E S</p> <p>1</p> <p>2</p> <p>For the Plaintiffs:</p> <p>3</p> <p style="padding-left: 40px;">NATHAN C. ZIPPERIAN, ESQ.</p> <p>4 SHEPHERD FINKELMAN MILLER & SHAH, LLP</p> <p style="padding-left: 40px;">1625 North Commerce Parkway</p> <p>5 Suite 320</p> <p style="padding-left: 40px;">Fort Lauderdale, Florida 33326</p> <p>6 (954) 515-0123</p> <p style="padding-left: 40px;">nzipperian@sfmslaw.com</p> <p>7</p> <p>8 For the Defendants:</p> <p>9 ROBERT DEEGAN, ESQ.</p> <p style="padding-left: 40px;">REED SMITH LLP</p> <p>10 10 South Wacker Drive</p> <p style="padding-left: 40px;">Fortieth Floor</p> <p>11 Chicago, Illinois 60606</p> <p style="padding-left: 40px;">(312) 207-6408</p> <p>12 rdeegan@reedsmith.com</p> <p>13 Also Present:</p> <p>14 Videographer Jonathan Williams</p> <p>15</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p> | <p style="text-align: center;">Page 4</p> <p style="text-align: center;">E X H I B I T S (Continued)</p> <p>1</p> <p>2 EXHIBIT DESCRIPTION PAGE</p> <p>3 Exhibit 10 Letter from Felicity H. 127</p> <p style="padding-left: 40px;">Barber to To Whom it May</p> <p>4 Concern</p> <p>5 Exhibit 11 Correspondence from United 129</p> <p style="padding-left: 40px;">HealthCare to Lori Atkins</p> <p>6 dated October 29, 2015</p> <p>7 Exhibit 12 Correspondence from United 129</p> <p style="padding-left: 40px;">HealthCare to Christine Endicott</p> <p>8 dated November 26, 2015</p> <p>9 Exhibit 13 Pages from the deposition of 134</p> <p style="padding-left: 40px;">Christine Endicott</p> <p>10</p> <p>11 Exhibit 14 Pages from the deposition of 141</p> <p style="padding-left: 40px;">Rachel Condry</p> <p>12 Exhibit 15 Pages from the deposition of 149</p> <p style="padding-left: 40px;">Laura Hipple</p> <p>13</p> <p>14 Exhibit 16 Correspondence from United 168</p> <p style="padding-left: 40px;">HealthCare to Christine Endicott</p> <p>15 dated November 26, 2015</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p> |
| <p style="text-align: center;">Page 3</p> <p style="text-align: center;">I N D E X</p> <p>1</p> <p>2 WITNESS: PAGE</p> <p>3 HENRY MILLER, Ph.D.</p> <p>4 Examination by Mr. Zipperian 6</p> <p style="padding-left: 40px;">Examination by Mr. Deegan 180</p> <p>5</p> <p>6</p> <p>7</p> <p>8</p> <p style="text-align: center;">E X H I B I T S</p> <p>9 EXHIBIT DESCRIPTION PAGE</p> <p>10 Exhibit 1 December 11, 2018 report 12</p> <p>11 Exhibit 2 Explanation of Benefits 78</p> <p style="padding-left: 40px;">Statement dated December 22,</p> <p>12 2015</p> <p>13 Exhibit 3 Website pages 83</p> <p>14 Exhibit 4 Instructions for filing for 83</p> <p style="padding-left: 40px;">insurance reimbursement</p> <p>15 document</p> <p>16 Exhibit 5 Explanation of Benefits 83</p> <p style="padding-left: 40px;">Statement dated December 23,</p> <p>17 2015</p> <p>18 Exhibit 6 Explanation of Benefits 83</p> <p style="padding-left: 40px;">Statement dated January 13,</p> <p>19 2016</p> <p>20 Exhibit 7 Explanation of Benefits 83</p> <p style="padding-left: 40px;">Statement dated December 16,</p> <p>21 2015</p> <p>22 Exhibit 8 Explanation of Benefits 83</p> <p style="padding-left: 40px;">Statement dated April 29,</p> <p>23 2016</p> <p>24 Exhibit 9 myuhc.com web page 87</p> <p>25</p> | <p style="text-align: center;">Page 5</p> <p>1 THE VIDEOTAPED DEPOSITION OF HENRY MILLER,</p> <p>2 Ph.D. was taken on January 11, 2019, commencing at 8:57</p> <p>3 a.m., at 2575 East Camelback Road, Suite 1100, Phoenix,</p> <p>4 Arizona, before Helen Pasewark, RPR, CSR, CCR, CLR,</p> <p>5 CRR, CR, a Certified Reporter in the State of Arizona.</p> <p>6</p> <p>7 THE VIDEOGRAPHER: Good morning.</p> <p>8 This is the video-recorded deposition of Henry</p> <p>9 Miller, Ph.D. in the matter of Condry versus</p> <p>10 UnitedHealth Group Incorporated. This deposition is</p> <p>11 taking place at Gallagher & Kennedy, 2575 East Camelback</p> <p>12 Road, Suite 1100, Phoenix, Arizona, 85016, on</p> <p>13 January 11, 2019 at 8:57 a.m.</p> <p>14 My name is Jonathan Williams. I'm the</p> <p>15 videographer with U.S. Legal Support located at 5757</p> <p>16 Anton Boulevard, Suite 400, Costa Mesa, California.</p> <p>17 Video and audio recording will be taking place</p> <p>18 unless all counsel agree to go off the record.</p> <p>19 Would all present please identify themselves</p> <p>20 beginning with the witness.</p> <p>21 THE WITNESS: My name is Henry Miller.</p> <p>22 MR. DEEGAN: Robert Deegan, Reed Smith, on</p> <p>23 behalf of UnitedHealth Group, defendants.</p> <p>24 MR. ZIPPERIAN: Nathan Zipperian of Shepherd</p> <p>25 Finkelman Miller & Shah on behalf of plaintiffs.</p> |

Page 6

1 THE VIDEOGRAPHER: Thank you. The certified
2 court reporter is Helen Pasewark. And would you now
3 please swear in the witness.
4
5 HENRY MILLER, Ph.D.,
6 having been first duly sworn to tell the truth, the
7 whole truth, and nothing but the truth, was examined
8 and testified as follows:
9
10 EXAMINATION
11 BY MR. ZIPPERIAN:
12 Q. Good morning, Dr. Miller.
13 A. Good morning.
14 Q. Thank you for being here today.
15 I know that you have given a significant
16 number of depositions before, but I'm going to go over
17 the ground rules just mostly for the record.
18 A. Sure.
19 Q. You understand that you are testifying here
20 today in the same manner which you would testify in
21 court? And by that I mean that the penalties of perjury
22 apply here as if you were in court. Do you understand
23 that?
24 A. I do.
25 Q. Okay. All your answers need to be audible.

Page 7

1 Uh-huh or huh-uh is difficult to determine what that
2 means sometimes later in the record, so if you say
3 uh-huh or uh-huh and I say is that a yes or is that a
4 no, I'm not trying to be rude. I'm just trying to be
5 clear. Okay?
6 A. Okay.
7 Q. You understand that the court reporter is
8 taking down everything we say today, and that makes it
9 important that we try to not talk over one another. I
10 will try and let you finish responding to a question
11 before I ask my next question, and I would ask that you
12 attempt to wait until I've finished asking my question
13 before you begin to answer it. Okay?
14 A. Okay.
15 Q. If you answer a question, I'm going to go
16 ahead and assume that you understood the question. Is
17 that fair?
18 A. Yes.
19 Q. If you don't understand a question or if you
20 don't hear it -- I'm both a low talker and coming off a
21 cold, so if you need me to speak up, let me know that
22 and I will do that. I'll make sure that you hear and
23 are understanding the question before you respond to it;
24 okay?
25 A. Okay.

Page 8

1 Q. If you need a break at any time, just let me
2 know. I will try and take a break about every hour or
3 so just for convenience sake. If you need a break
4 before that time, like I said, just let me know, we'll
5 take a break. The only thing I would ask, if there is a
6 question pending, that you respond to that question
7 before the break; okay?
8 A. Okay.
9 Q. All right. What did you do to prepare for
10 today's deposition?
11 A. I reviewed my file of documents related to the
12 case and my report and I met with Mr. Deegan yesterday.
13 And two other people were in the videoconference for
14 that preparation.
15 Q. Who were those people?
16 A. Rebecca Hanson and Doug Hewitt.
17 Q. Approximately how long did that meeting last?
18 A. It lasted about five hours.
19 MR. DEEGAN: I'll just caution the witness at
20 this point not to reveal communications. Some things
21 are privileged communications.
22 BY MR. ZIPPERIAN:
23 Q. What consists of your file on this matter?
24 A. Well, it includes my report -- my reports and
25 the documentation that's referenced in the notes to my

Page 9

1 report. I would say that that's pretty much it.
2 Q. Nothing else that you can remember as you sit
3 here today that's in that file?
4 A. No.
5 Q. Do you have billing records related to this
6 case in that file or is that kept separately?
7 A. That's kept separately.
8 Q. Did you speak with anyone at United HealthCare
9 in order to prepare for today's deposition?
10 A. No.
11 Q. Okay. There may be a couple terms I use
12 today, United HealthCare, UHC or UHG. Can we all agree
13 that we're all talking about the same thing when I use
14 one of those terms?
15 MR. DEEGAN: When you use that one particular
16 acronym?
17 BY MR. ZIPPERIAN:
18 Q. In my mind it's UHC. I notice in your report
19 you used UHG. I'm sure I'll say United HealthCare at
20 some point. Unless there's a specific reason to
21 specify, can we just agree that we're talking about
22 United HealthCare, the defendants in this matter?
23 A. That's fine.
24 MR. DEEGAN: I think that's fine.
25 MR. ZIPPERIAN: Okay.

Page 10

1 Q. If that becomes an issue at any point for any
2 reason, just let me know.
3 Did you speak with anyone in your office in
4 order to prepare for today's deposition other than the
5 attorneys that you've already mentioned?
6 A. No.
7 Q. Did you communicate with anyone at United
8 HealthCare in relation to preparing either of your
9 reports in this matter?
10 A. No.
11 Q. Other than the meeting and conference call
12 yesterday, were there any previous either calls or
13 meetings with counsel for United HealthCare in order to
14 prepare for today's deposition?
15 A. I certainly had phone calls with them
16 previously but without a focus on preparing for the
17 deposition.
18 Q. Okay. So phone calls in relation to this
19 matter but not necessarily specifically to prepare for
20 today?
21 A. That's correct.
22 Q. All right. Approximately how many phone calls
23 have you had with United HealthCare's attorneys in
24 relation to this matter?
25 A. I don't know. I mean, it's --

Page 11

1 MR. DEEGAN: Over what course of time?
2 BY MR. ZIPPERIAN:
3 Q. Over the entire course of your representation.
4 A. I couldn't really give you a number.
5 Q. Okay. United HealthCare's attorneys in this
6 matter is a firm called Reed Smith; is that correct?
7 A. That's correct.
8 Q. Are you currently working with Reed Smith on
9 any other matters?
10 A. Yes. They're not active right now in that I'm
11 not doing anything related to them right now, but the
12 cases are still active.
13 Q. How many cases are you working on with Reed
14 Smith?
15 A. I can only think of two.
16 Q. What's the nature of your retention in those
17 matters? Are you being asked to testify as an expert in
18 those matters as well?
19 A. In one matter that's correct. In another
20 matter it's a consulting role.
21 Q. What types of cases are those?
22 A. Well, one of them relates to a different array
23 of health insurance benefits and the other one relates
24 to a situation involving a medical school and
25 accreditation requirements.

Page 12

1 MR. DEEGAN: And I'll caution, Dr. Miller, to
2 the point there are additional questions along these
3 lines, if information is subject to confidentiality
4 orders in those cases, just keep that in mind.
5 BY MR. ZIPPERIAN:
6 Q. As you sit here today do you recall the names
7 of those cases?
8 A. No.
9 Q. Do you know --
10 A. Well, the specific names, no.
11 Q. Do you know either of the parties in either of
12 those cases?
13 A. Yes. One of the cases, one of the parties is
14 Anthem Blue Cross Blue Shield and the other case there's
15 not been a lawsuit filed.
16 Q. Where's the Anthem Blue Cross Blue Shield case
17 pending?
18 A. I believe in Kentucky.
19 Q. Reed Smith is representing Anthem Blue Cross
20 in that case?
21 A. Yes.
22 MR. ZIPPERIAN: Let's go ahead and mark as
23 Exhibit 1 to your deposition your December 11, 2018
24 expert report.
25 (Exhibit 1 was marked for identification.)

Page 13

1 MR. ZIPPERIAN: And we'll refer to that as
2 Miller 1.
3 Q. I'm going to ask you first to turn to page 19.
4 And that's part of Appendix A to your report, which is
5 your CV. Page 19 lists your educational background and
6 it says you have a Ph.D. in accounting and economics.
7 Is that correct?
8 A. That's correct.
9 Q. When did you get that Ph.D.?
10 A. 1971.
11 Q. And you went to the City College of New York
12 for your undergraduate degree?
13 A. Yes.
14 Q. What was that in?
15 A. Accounting.
16 Q. And then you got your MBA from City College of
17 New York. Was that also, obviously, a master's in
18 business administration?
19 A. Yes.
20 Q. Was there a specialized discipline that you
21 specialized in while you were getting your MBA?
22 A. No official specialization, but most of the
23 courses, other than the required courses, that I took
24 were in accounting and economics.
25 Q. Do you hold any other degrees?

Page 14

1 A. No.

2 Q. Do you have any other certifications or

3 specialized training since you got your Ph.D.?

4 A. I -- I did hold a certified public accountant

5 license for a few years, and meaning that I passed that

6 exam, but I don't maintain that license anymore.

7 Q. Do you have any medical training?

8 A. No.

9 Q. Have you ever worked in a medical facility, a

10 doctor's office, or a hospital?

11 A. Well, worked certainly as a consultant on many

12 occasions. I also was on the board of a hospital and

13 chaired that board. I was never a direct employee of a

14 hospital or a physician practice, but I have consulted

15 with many.

16 Q. What was the hospital that you were the

17 chairman of the board for?

18 A. Howard County General Hospital.

19 Q. Where is that located?

20 A. In Columbia, Maryland. It's a subsidiary now

21 of Johns Hopkins medical system.

22 Q. What years were you the chairman? It's right

23 here on your CV. Is it 1987 to 1989? Is that accurate?

24 A. That's correct.

25 Q. What were your duties as chairman of the board

Page 15

1 of trustees for the hospital?

2 A. Interact with hospital management, chair

3 meetings, have oversight over the activities of the

4 hospital in general.

5 Q. Your CV indicates that you are currently

6 working as the managing director, health analytics at

7 Berkeley Research Group. Is that right?

8 A. That's right.

9 Q. What do you do in that capacity?

10 A. I am one of several managing directors.

11 Managing director title means that I am the most

12 senior -- in the most senior category of staff. And

13 what I do is work on cases and projects that relate to

14 healthcare. Fairly broad array of types of projects,

15 but all related to healthcare and almost always relating

16 to health insurance issues.

17 Q. When you say work on cases and projects, does

18 that mean work as an expert witness or consultant or is

19 there some other work that you do?

20 A. Well, some of the work -- the term consultant

21 is a broad term, could mean a lot of different things,

22 but a lot of my work, but certainly not all of it, is

23 related to expert witness or work or consulting work

24 relating to litigation, but I also do a considerable

25 amount of work as a consultant to other entities, state

Page 16

1 government health plans, occasionally hospitals.

2 Q. What percentage of your work is devoted to

3 litigation currently?

4 A. Currently, I would say about 60 percent.

5 Q. What did you do before you were the managing

6 directly at Berkeley Research Group?

7 A. I was a managing director at another firm,

8 LECG, doing similar work. Prior to that I was a

9 managing director at Navigant Consulting, which I did

10 the same thing. And prior to that I founded and ran an

11 organization called the Center for Health Policy Studies

12 for 20 some years. And there I was president,

13 responsible for the organization, but the bulk of my

14 time was spent doing the same thing that I do now.

15 Q. Why did you leave the Center for Health Policy

16 Studies?

17 A. Well, I didn't exactly leave it. I sold it to

18 Navigant Consulting.

19 Q. Why did you leave Navigant?

20 A. The individuals who I was closest to and who

21 had been active in the purchase of the Center for Policy

22 Studies left Navigant to join LECG and recruited me to

23 join them, which I did.

24 Q. And then why did you leave LECG?

25 A. Well, by that time there was a small group of

Page 17

1 us, the same people that I worked with at Navigant, who

2 were interested in other opportunities and it was around

3 the same time that Berkeley Research Group was being

4 formed and so we became among the small group of

5 founding members of the Berkeley Research Group.

6 Q. On page 15 of your expert report in the bottom

7 paragraph, there you say -- it says:

8 "Dr. Miller has worked with more than 50

9 health plans, including some of the largest

10 plans in the U.S."

11 When you say that you've worked with more than

12 50 health plans, what does that mean?

13 A. On a consulting basis I've been retained by

14 them to do various projects. More recently those

15 retentions have been related to litigation, but not

16 always. And in the past they related more to reviews

17 and evaluations of their processes or various elements

18 of their activities.

19 Q. Do you testify as an expert for both

20 plaintiffs and defendants?

21 A. Well, sometimes the plaintiffs are defendants.

22 Q. I'm sorry. Plaintiffs and defendants.

23 A. Oh, plaintiffs and defendants. Yes, I do.

24 Q. What would you estimate the percentage of your

25 testimony is split along those lines?

Page 18

1 A. The majority of my testimony is for
2 defendants, although it is -- there isn't necessarily a
3 consistency. I have testified for health plans, for
4 example, when they've been plaintiffs or defendants, so
5 it's not exactly an easy comparison, but I've also
6 testified in cases involving plaintiffs against health
7 plans.
8 Q. In the last three years how many times have
9 you testified on behalf of an individual plaintiff as an
10 expert witness?
11 A. On behalf of an individual plaintiff? I can
12 only think of one.
13 Q. What case was that?
14 A. That was a qui tam case, a whistle-blower case
15 against DaVita, which is a one of the largest providers
16 of kidney dialysis services in the U.S.
17 Q. Where was that case pending?
18 A. Georgia, I believe.
19 Q. Expanding on that a little bit, in the last
20 three years how many times have you testified on behalf
21 of a plaintiff who was not a healthcare plan?
22 A. Oh. A few times. Probably easier if you look
23 at my list of testimony and I can tell it from that.
24 And you're only interested in cases where I testified
25 for a plaintiff but the plaintiff was not a health plan?

Page 19

1 Q. Correct.
2 A. Because I testified in a number of cases where
3 there were no health plans involved.
4 Well, in one case listed on page 21 of my CV,
5 there's a case, three up from the bottom, Prime
6 Healthcare Services versus Blue Mountain Capital, and I
7 testified for Prime Healthcare Services.
8 And on the top of page 22, University Health
9 of Shreveport and Vantage Health Plan, I testified for
10 the plaintiff in that case.
11 In the -- let's see -- four down from the top,
12 Sodexo Laundry Services versus Angelica Textile
13 Services, I testified for Sodexo, who is the plaintiff.
14 Over the last three years those are the ones
15 that I can identify. I may have been involved in other
16 cases where I didn't actually testify but which I was
17 retained as an expert witness but the case may have been
18 settled or whatever.
19 Q. Are there any cases that you can remember as
20 you sit here today that in the last three years in which
21 that was the case, with where you were retained as a
22 consultant for a plaintiff who is not a healthcare plan
23 but did not testify?
24 A. I can't think of any. I know I did that, but
25 I couldn't remember specifically which ones.

Page 20

1 Q. Approximately how many times did that happen
2 in the last three years?
3 A. I'd say four or five times.
4 Q. I noted that you had 68 cases listed on your
5 CV in which you've testified or given deposition
6 testimony, I believe, since 2011. Forty-six of those
7 are in the last three years. Is there any reason why
8 there's been such a significant uptick?
9 A. Yes. About four years ago I became involved
10 in providing expert testimony in personal injury cases,
11 a very specialized part of those personal injury cases
12 dealing with the valuation of future medical expenses.
13 The cases, as far as my involvement is involved, are
14 fairly small. My involvement is fairly limited, but it
15 has resulted in a significant amount of testimony.
16 Mostly deposition testimony. Those cases don't come to
17 trial very often.
18 Q. But there are lots of them; right?
19 A. There is lots of them, exactly. And I think
20 they probably over the last three years may -- or out of
21 all of the cases listed on my CV, they're -- more than
22 half of those cases are related to those personal injury
23 cases.
24 Q. I believe the number is 29 personal injury
25 cases in which you've testified. In all of those cases

Page 21

1 were you testifying regarding the valuation of future
2 medical expenses?
3 A. On the valuation of medical expenses and the
4 applicability of Affordable Care Act coverage to the
5 plaintiff.
6 Q. And was your testimony in all those cases for
7 defendants?
8 A. Yes.
9 Q. Have you ever used remark codes for billing in
10 any of your work?
11 A. Well, how do you mean used them?
12 Q. Distributed remark codes, received remark
13 codes. I mean other than testifying about them as an
14 expert.
15 A. Yeah, I've -- the term "used" is not --
16 doesn't really apply, but I certainly have reviewed and
17 analyzed remark codes in situations other than as --
18 other than in litigation situations.
19 Q. And when was that?
20 A. Oh, it's been on several occasions. In the
21 work that I've done for health plans, non-litigation
22 work for health plans, a lot of that work is evaluation
23 of existing systems that are in place relating to
24 submission of claims and claims payment and rates at
25 which payment is made to providers, and in the course of

Page 22

1 that work, for at least a few clients, I've -- I've
2 evaluated -- evaluate is not quite the word -- analyzed
3 remark codes that they've used. I've reviewed them.
4 Q. Who are those clients that you reviewed their
5 remark codes for?
6 A. Mostly Blue Cross and Blue Shield plans: Blue
7 Cross and Blue Shield of Florida, which is now known as
8 Florida Blue; Blue Cross Blue Shield of New Jersey,
9 which is Horizon Blue Cross and Blue Shield.
10 I've been working for more than 20 years as a
11 consultant to a health plan in Oklahoma that is run by
12 the state, the Oklahoma State Employees Group, which is
13 actually a very large health plan. It's the second
14 largest health plan in Oklahoma, and I've done that work
15 for them as well.
16 Did some of that work as well for Blue Cross
17 Blue Shield of Texas, which is part of Healthcare
18 Services Corporation. Those are the ones that come to
19 mind immediately.
20 Q. When did you do that work for Blue Cross Blue
21 Shield of Florida?
22 A. That's been -- they've been a continuous
23 client for probably 25 years or so, but I would say this
24 particular work that I'm describing was done about three
25 years ago.

Page 23

1 Q. Did you issue a written report to them in
2 conjunction with your review?
3 A. No.
4 Q. What about for the healthcare plan in
5 Oklahoma, when did you perform that work for that
6 client?
7 A. That's been continuous. Some of that has been
8 fairly recent, although I initially looked at remark
9 codes as part of their overall claim processing system
10 probably going back about 15 years, but I've reviewed
11 them from time to time when issues have arisen and I
12 would say most recently about two years ago.
13 Q. Did you issue a written report to them two
14 years ago in conjunction with your review of their
15 remark codes?
16 A. No.
17 Q. What are the types of issues that arise that
18 require you to review the remark codes?
19 A. They're not -- they're not really difficult
20 issues. The work -- I wasn't retained for the purpose
21 of reviewing the remark codes. I was retained for the
22 purpose of reviewing their entire process for submission
23 and payment of claims. And in that work, obviously, one
24 of the pieces of it is to examine the information
25 included in explanation of benefits, in the EOBs, and

Page 24

1 that as well as provider remittances, and part of the
2 work that I did -- that I was asked to do -- was to
3 review the language in the remark codes that they use.
4 Q. Did you make any suggestions as to how they
5 can change their remark codes?
6 A. Not specific suggestions such as rewriting
7 them, no. My work was more focused on whether or not
8 the remark code captured the intent of what was to be --
9 what was to be communicated.
10 Q. And did you determine that they did?
11 A. Most of the time.
12 Q. Were there instances where you determined that
13 it did not and you recommended changes?
14 A. Sure.
15 Q. Do you remember what changes you recommended?
16 A. Not specifically at this point, no.
17 Q. And although we were talking specifically
18 about the Oklahoma health plan in that last set of
19 questions, is the same -- have you been doing the same
20 type of work for the other plans or are there notable
21 differences?
22 A. No. Similar. And -- yes, similar work.
23 Q. Have you issued a written report with regards
24 to remark codes or potential changes to remark codes to
25 any of the healthcare plans that you've worked with?

Page 25

1 A. No. These are all consulting assignments
2 where I did my work, had staff do work and then made
3 presentations on the findings of the work or in meetings
4 or however, but there were no written reports for that
5 work.
6 Q. Did any of the presentations contain
7 information or recommendations related to remark codes?
8 A. Only to the extent that that was part of the
9 scope of the work.
10 Q. As you sit here today can you remember any
11 instance in when you gave a presentation that called for
12 changes to remark codes or recommended changes to remark
13 codes?
14 A. No.
15 Q. Over -- since 2011 you have 68 cases listed on
16 your CV in which you've testified. Do you have any
17 approximation of how many times you've been retained in
18 cases but did not testify in that same time period?
19 A. Well, in order to answer the question, I have
20 to separate the personal injury cases from the -- from
21 my other cases, and in the other cases I would say
22 probably eight to ten times. In the personal injury
23 cases they would be many more, 50 or more. That's very
24 common in those cases, for me to prepare a report and
25 then the case be settled before there was testimony.

Page 26

1 Q. I'm going to direct you back to page 19 of
2 Miller No. 1. On that page you list a number of areas
3 in which you have testified or offered expert testimony
4 and it looks like there's 10 are 12 different bullet
5 points there. Do you see that?
6 A. I do.
7 Q. One of those bullet points is class action
8 certification. Do you see that?
9 A. I do.
10 Q. How many times have you testified as an expert
11 with regard to class action certification?
12 A. In thinking about it, I can think of four. I
13 don't know that there were any others.
14 Q. Out of those -- are those four cases listed in
15 your CV?
16 A. The last one listed for 2011 is -- actually,
17 the last two are both cases that I was thinking of, the
18 Russell Hospital Corporation case in New Mexico and the
19 Progressive Insurance case in Washington.
20 I was involved in or testified on class
21 certification issues in another Progressive case perhaps
22 in 2009 that's not listed here. And there was another
23 one also earlier that -- in Pennsylvania where my client
24 was a subsidiary of Health Net, which is a health plan.
25 Q. In those four cases did you testify in support

Page 27

1 of or in opposition to class certification? Or if
2 there's a mixture, I would like to know what that is.
3 A. I testified in opposition to class
4 certification.
5 Q. In each of the four cases?
6 A. Yes.
7 Q. And do you recall what the outcome was with
8 regards to class certification in any of those cases?
9 A. If I'm remembering correctly, I think in three
10 of the cases the class certification was denied and in
11 one case it was approved.
12 Q. In which case was class certification
13 approved?
14 A. In the last one that I mentioned in
15 Pennsylvania for Health Net; but in the other cases that
16 I mentioned, class certification was not approved.
17 Q. Is it accurate to say that you've not
18 testified since 2011 with regards to class
19 certification?
20 A. That's correct.
21 Q. Have you been retained as a consultant with
22 regards to class certification since 2011?
23 A. No.
24 Q. Approximately what percentage of your current
25 litigation work is related to personal injury case?

Page 28

1 A. The percentage of litigation work?
2 Q. Em-hmm.
3 A. That I'm doing? How are we measuring this?
4 The reason I ask is because for many of those cases,
5 while I do prepare reports and testify, I don't do the
6 underlying work, so I don't spend that much time on it.
7 But if you just count the cases, I would say probably
8 about two thirds of the cases that I'm currently working
9 on litigation are personal injury cases, but in terms of
10 the amount of work that I do on them is probably more
11 like one third.
12 Q. What about in terms of income that you derive
13 from your litigation practice?
14 A. About 50/50. Of course, I don't derive any
15 income from them. Berkeley Research Group derives the
16 income.
17 Q. Are you an owner of Berkeley Research Group?
18 A. I am a member; yes.
19 Q. Is your income dependent on the amount of
20 income that Berkeley Research Group takes in?
21 A. Well, certainly not directly, no.
22 Q. Okay. So what do you mean when you say not
23 directly?
24 A. Well, I have a salary and that's not related
25 to the work that I bring in. I have a bonus which -- in

Page 29

1 which is calculated, and one of the factors is related
2 to the work that I bring in.
3 Q. What are the other factors?
4 A. How good a guy I am. You know --
5 Q. Well, that's a good factor.
6 A. It's a subjective process the way we work it.
7 Q. How many members are there in Berkeley
8 Research Group?
9 A. I would say at this point in time probably
10 about 350.
11 Q. 350?
12 A. Yes.
13 Q. That's a nationwide company? They have
14 offices all over the country; is that right?
15 A. International as well, yes.
16 Q. How many people are in the Phoenix office?
17 A. Twelve.
18 Q. Have you ever testified or given a written
19 report in an ERISA-related case?
20 A. I have. Not often. But there were ERISA
21 issues in cases that I testified in.
22 Q. What cases were those?
23 A. There were two recent cases listed here. The
24 second case in the list under 2018 is Deborah Innis
25 versus Bankers Trust of South Dakota. That had ERISA

Page 30

1 implications in it. And the top case on page 21, the
2 Jackson -- no, that's not -- oh.
3 The fourth case is the one I was trying to
4 find. Lisa Allen and Misty Dalton on behalf of the
5 Personal-touch Employee Stock Ownership Plan versus
6 GreatBanc. Those both had ERISA issues raised and
7 they've been -- I've addressed ERISA issues in a number
8 of my consulting assignments as they relate to the
9 responsibilities of health insurers when they're dealing
10 with clients or customers that are ERISA plans.
11 Q. What was the scope of your testimony in the
12 Innis case?
13 A. Both of the cases that I mentioned were cases
14 where an employee stock ownership plan was disputing the
15 valuation of the company of which -- that had been
16 established at the time that the employees' stock
17 ownership plan began, and both of the entities are ERISA
18 companies and there are a number of issues relating to,
19 among other things, health insurance, and those are ones
20 that I was concerned about as they related to ERISA as
21 part of the case.
22 Q. Were you recognized as an ERISA expert in any
23 of those cases -- either of those cases?
24 A. No.
25 Q. Have you ever been recognized as an ERISA

Page 31

1 expert by a court?
2 A. No.
3 Q. Do you consider yourself an ERISA expert?
4 A. No.
5 Q. What do you consider the area of your
6 expertise?
7 A. Healthcare finance in general and specifically
8 health insurance, health coverage and measurement of the
9 cost of healthcare. And in the broad area of health
10 insurance I'm including Medicare and Medicaid.
11 Q. Do you consider yourself an expert in the use
12 of remark codes?
13 A. Hard question to answer. I haven't actually
14 been asked whether I'm an expert in that. Remark codes
15 are not an area that generally demands that much
16 attention. I understand remark codes. I understand how
17 they're developed. I understand how they're used. I've
18 never been asked the question whether I'm an expert in
19 it before, so I don't know. Maybe.
20 Q. Maybe? What would you say makes you an expert
21 in remark codes?
22 A. Oh. Well, understanding how they are
23 developed and how they are used. I think that's what
24 requires expertise.
25 Q. And what's the basis for your expertise in how

Page 32

1 remark codes are developed and used?
2 A. It's something that I have studied and talked
3 about and presented on for several years.
4 Q. When you say you've presented on, is that in
5 your consulting role or have you made public
6 presentations regarding the use of remark codes?
7 A. No. In my consulting role.
8 Q. Are those written presentations?
9 A. No. Well, you know, they're -- do you mean is
10 there a narrative that I've read from for the
11 presentation?
12 Q. Or a PowerPoint presentation or something like
13 that.
14 A. There are some PowerPoint presentations.
15 Q. Is that something that you maintain?
16 A. Sometimes.
17 Q. And specifically I'm asking if we asked you to
18 produce presentations in which you've made presentation
19 about remark codes, would that be something you'd be
20 able to do?
21 A. No, because the work that those presentations
22 relate to would be confidential work for a client.
23 Q. But it is something that you've maintained a
24 copy of?
25 A. I may have. I don't know. I would have to go

Page 33

1 back and look, but sometimes I do, sometimes I don't
2 depending upon circumstances. So I may have copies of
3 one or more of those presentations, but I'm not sure.
4 Q. Have you ever testified in a case involving
5 lactation support services?
6 A. Not prior to this case, no.
7 Q. Have you ever been retained in a case other
8 than this one relating to lactation support services?
9 A. No.
10 Q. Have you ever testified outside of the
11 personal injury context regarding the interpretation of
12 the ACA?
13 A. In an expert testimony capacity?
14 Q. Yes.
15 A. I think so. I'd have to go back and look.
16 Q. There's a lot of them.
17 A. Yeah. And it's -- it's not as easy to
18 remember. I would say I have, but in passing. It
19 hasn't been the subject of the litigation, but it has
20 been something that I would have -- that I did discuss
21 as part of my testimony or a report.
22 Q. And as you sit here today can you remember
23 what case that was?
24 A. Well, I have to think about it more
25 specifically, but I know that there was -- there was a

Page 34

1 case in Kentucky where that was -- where that was an
2 issue.

3 I have to supplement my answer by saying that
4 I have worked as a consultant on ACA issues on several
5 occasions. I'm struggling to find whether I remember
6 whether I testified about it. I testified about it in
7 the personal injury cases quite a bit, but nonpersonal
8 injury cases, I can just think of that one case in
9 Kentucky that had to do with overall health insurance
10 coverage. But in my consulting work, I've worked with
11 health insurers to design their products for the -- to
12 place on the insurance exchanges in different states and
13 I've served as an internal expert within Berkeley
14 Research Group on the ACA.

15 Q. I did note in your CV that you testified to
16 Congress at some point. First of all, when was that
17 testimony?

18 A. About six, seven years ago.

19 Q. And one instance of testifying? I didn't mean
20 to diminish that at all.

21 A. No. That's fine. I saved the country.

22 Q. What was the nature of your testimony?

23 A. I was testifying on an issue relating to the
24 impact of potential insurance company mergers on -- on
25 providers and patients in the state of Pennsylvania. It

Page 35

1 was an anticompetition/antitrust issue before the Senate
2 Finance Committee.

3 Q. Have you ever testified before about the use
4 of remark codes?

5 A. No.

6 Q. Have you ever testified before about the
7 purpose of remark codes?

8 A. No.

9 Q. Have you ever testified before about the
10 clarity of remark codes to an average insured?

11 A. No. The issue of remark codes has very rarely
12 come up in a litigation context, as far as my
13 experience.

14 Q. Do you consider yourself to be an expert in
15 the purpose of remark codes?

16 A. I think that's a difficult question because I
17 don't know that that is an area where experts are
18 declared, but I certainly feel as though my knowledge of
19 them and my experience with them would make me an
20 expert.

21 Q. And is there something other than your
22 experience in the field that would make you an expert on
23 them? By that I mean any particular training or
24 specialization that relates to the remark codes.

25 A. The use of remark codes is an element of

Page 36

1 claims processing for health insurers, and I definitely
2 consider myself to be an expert in claims processing,
3 and since remark codes are an element of that, I would
4 consider myself to be an expert there as well.

5 Q. And is the basis for your belief that you are
6 an expert in claims processing your experience in the
7 field, any specialized training or education related to
8 claims processing?

9 A. It's based on my experience. I'm not aware of
10 any specialized training for that.

11 Q. Have you ever been stricken as an expert?

12 A. Stricken?

13 Q. Or excluded?

14 A. In two instances.

15 Q. Let's talk about those separately. When was
16 the first time that happened?

17 A. 2013 or 2014, around there.

18 Q. What was the name of that case?

19 A. That was Children's Hospital of Central
20 California versus Blue Cross of California.

21 Q. Who were you testifying on behalf of?

22 A. I was testifying on behalf of Blue Cross of
23 California and my testimony was in state court and my
24 testimony was excluded after my deposition in the lower
25 court. The case went to appeal and the California Court

Page 37

1 of Appeal indicated or opined or issued their opinion
2 that I should have been allowed to testify and, in fact,
3 sent the case back to be retried and it was not retried.
4 It was eventually settled.

5 Q. Is that case listed on your CV?

6 A. Yeah.

7 Q. I see it under -- it's in the 2012, second one
8 down; is that right?

9 A. I think my deposition was in 2012 and...

10 Q. Yeah.

11 A. And the action through the appeals process
12 took place through probably 2015 or 2016.

13 Q. The wheels of justice.

14 A. Yeah. It was an interesting opinion from the
15 Court of Appeals because it actually endorsed the method
16 that I was using which the Court initially had said was
17 not in accordance with the statute and changed --
18 certainly created a new precedent for those kinds of
19 cases in California and it gave me a lot more work.

20 Q. What was the scope of your testimony in that
21 case? Was that a personal injury case?

22 A. No. No. That was a case where Children's
23 Hospital Central California had provided services to a
24 large number of children who were members or whose
25 parents were members of Blue Cross California's Medicaid

Page 38

1 managed-care plan and the Blue Cross of California had
2 paid Children's Hospital at the Medicaid rates for those
3 services and Children's Hospital wanted to get paid
4 their full charges for those services, which were a lot
5 higher, and my testimony related to what was the actual
6 valuation of those services, what were they actually
7 worth.
8 Q. That's actually fairly interesting but not
9 particularly relevant to today.
10 Second time that you were excluded, when was
11 that?
12 A. That was a case in Georgia where -- the case
13 is the Ishmael case, personal injury case, where the
14 judge was not very clear on why I was excluded, but
15 ultimately I learned it was because of violation, in his
16 mind, of the collateral source rule, which is a key
17 element in personal injury cases, and that the defendant
18 can't rely on the collateral source to pay damages. And
19 of course it was not -- that's not what I do and that
20 was not -- but that was what the judge decided.
21 I found it interesting that in the more recent
22 case, the Gaddy case, which was also in Georgia, another
23 judge ruled specifically, because the motion had been
24 submitted to exclude me, specifically ruled specifically
25 that I could testify on those same issues that I had

Page 39

1 been excluded from previously. But those are the only
2 two times that I'm aware of that my testimony has been
3 excluded.
4 Q. What was the name of the case in Georgia?
5 A. The one where I was excluded is Ishmael. It
6 was -- it's on the top of page 23, Ashlie Danielle
7 Ishmael versus General Growth Properties.
8 Q. Do you know how much Berkeley has invoiced to
9 date for your time in this case?
10 A. I'm not sure. I usually look that up before a
11 deposition, but I forgot to do that this time, so I'm
12 not certain.
13 Q. Do you have an approximation?
14 A. And given that it would have to be a broad
15 approximation, I would say 40- to \$50,000.
16 Q. How long did you spend preparing the report,
17 December 11, 2018 report, that's marked as Miller No. 1?
18 A. Do you mean how much time did I personally
19 spend on it?
20 Q. Yes.
21 A. I would say, over an extended period of time,
22 probably 40 to 50 hours.
23 Q. And do you have staff that assist you in
24 preparation of expert reports?
25 A. Usually, yes, but not in this case.

Page 40

1 Q. And why not in this case?
2 A. Well, because the staff that I use generally I
3 use for basic research and for data analysis and there
4 wasn't really any data analysis to be done in this case
5 for me and I did the research myself. It was just an
6 issue of wanting to.
7 I like to understand the issue that I'm
8 addressing as thoroughly as possible, so when the need
9 for research is pretty general and I feel as though I'm
10 not going to be learning anything new, I generally give
11 that to staff, but in a lot of cases, like this case is,
12 I do the research myself.
13 Q. Did you learn anything new in your research in
14 this case?
15 A. Not really. I expanded my knowledge, clearly,
16 but it's more a matter of refreshing my knowledge than
17 it was learning anything new. And I say learning
18 something new, I probably should say that this was just
19 very interesting to me.
20 Q. Okay. What were -- what types of research did
21 you do?
22 A. Well, mostly internet research and research
23 relating to remark codes. And then the other research
24 was review of documentation that had been produced to me
25 by Reed Smith relating to declarations and depositions

Page 41

1 and explanations of benefits.
2 I did go through the process of seeking to
3 identify -- doing research and seeking to identify how
4 other insurers use remark codes as part of my interest
5 in this.
6 Q. Okay. What did you do to research how other
7 insurers used remark codes?
8 A. I maximized my Google time. I primarily used
9 the internet. Found it remarkable that -- as I always
10 do -- that there's so much there that you don't
11 necessarily expect to see, but I was able to identify
12 several EOB forms from different insurers.
13 Q. Approximately how many hours did you spend
14 doing internet research?
15 A. Eight to ten hours maybe.
16 Q. Did you review any academic books, compendia,
17 anything like that in performing your research?
18 A. No. I looked for them, but there really
19 aren't any academic --
20 Q. Materials?
21 A. -- publications on this topic, at least not
22 that I could find.
23 Q. How much time did you spend reviewing
24 documents related to this case? And by that --
25 A. You mean documents related to this case?

Page 42

1 Q. Yeah. So I'm distinguishing that from more
2 generalized research on the internet.
3 A. I would say similar to the other answer I
4 gave, eight to ten hours. Maybe eight hours is closer
5 to it.
6 Q. And were the documents that you reviewed all
7 documents that had been provided to you by defense
8 counsel?
9 A. Yes.
10 MR. ZIPPERIAN: Why don't we take five
11 minutes. It's been a little over an hour.
12 THE VIDEOGRAPHER: This ends Media 1 in the
13 deposition of Henry Miller, Ph.D. We are off the
14 record at 10:03 a.m.
15 (Recess held.)
16 THE VIDEOGRAPHER: This begins Media 2 in the
17 deposition of Dr. Henry Miller. We are on the record
18 at 10:11 a.m.
19 BY MR. ZIPPERIAN:
20 Q. Dr. Miller, we were talking about the
21 preparation of your report marked as Miller No. 1.
22 There are a number of documents listed throughout the
23 report. Other than those documents, did you review
24 anything else in terms of case-related documents in
25 order to prepare your report?

Page 43

1 A. I don't think so, no.
2 Q. And that was a poorly worded question, but you
3 understand I'm asking you if there were things that you
4 looked at that you used to prepare your report that are
5 not listed in the report itself?
6 A. Well, the answer to that is different.
7 Certainly, I mentioned the internet research that I did
8 and other -- well, it was all internet research,
9 investigations that I did on specific issues, and
10 certainly not all of that is listed in the report, but
11 in terms of documents that relate specifically to the
12 case, I believe that everything that I've listed in my
13 report is what I looked at.
14 Q. Okay. Among the things listed are portions of
15 depositions of some of the plaintiffs in the case; is
16 that right?
17 A. Yes.
18 Q. Did you review the entire deposition
19 transcripts for those depositions or just portions?
20 A. I reviewed -- in some -- well, in the cases of
21 all the depositions I had for plaintiffs, I reviewed
22 portions in some depth that I was directed to or that,
23 you know, were specifically on point. I did review the
24 entire depositions, but I skimmed a lot of the material.
25 Q. Was any portion of this report written by

Page 44

1 someone other than yourself?
2 A. No.
3 Q. Was any portion of this report cut and pasted
4 from another report?
5 A. No.
6 Q. Did you type the report yourself?
7 A. Well, yeah.
8 Q. Were there any drafts of this report before
9 the final draft?
10 A. Well, the way in which I work, I am preparing
11 the report, I don't have any drafts, but not to say that
12 I sat down and wrote it word for word from start to
13 finish just as it is now. It took a lot of review, but
14 there are no formal drafts.
15 Q. How many iterations of the report were there
16 before it was finalized, if you know?
17 A. I don't.
18 Q. I'm going to direct you to page 1 of the
19 report. In the third paragraph of that page it says:
20 "I have also conducted reviews that
21 required ERISA requirements regarding the
22 clarity of communications between payers and
23 insureds."
24 Do you see that?
25 A. I do.

Page 45

1 Q. What does that mean?
2 A. It refers to the requirements of payers -- and
3 by payers I mean health insurers -- interpreting ERISA
4 plan documents and whether their specific communications
5 to ERISA plans reflect the plan documents. I'm working
6 on such a case right now.
7 Q. What ERISA requirements are you referring to?
8 A. Well, within most ERISA plans there are
9 requirements for communications that are going to be
10 made to members or to employees of the ERISA company
11 that relate specifically to their health insurance.
12 That's pretty much what I'm referring to.
13 Q. And do you know the specific ERISA
14 requirements you are referring to?
15 A. I'm just drawing a blank, but the -- there are
16 requirements -- not requirements, but plan documents
17 include information about, for example, in one instance
18 that's coming to mind, how -- what the difference is
19 between in-network and out-of-network payment.
20 Another issue is whether or not, for providers
21 that are not in the plan's network, whether the ERISA
22 plan will allow assignment of benefits. Those are the
23 sorts of things that I was referring to. I mean, those
24 are the ones -- I mean, there's a variety of things, but
25 those happen to be the ones that come to mind now.

Page 46

1 Q. For whom did you conduct the reviews?

2 A. Well, the one that I'm talking about right

3 now, I'm thinking about right now, is for a client in a

4 litigation context where the issue is how much should be

5 paid and by who for out-of-network services provided to

6 participants in the ERISA plan, and my work is being

7 done for a health plan.

8 Q. Which health plan?

9 A. Don't know that I can say.

10 Q. Okay.

11 A. I did sign a confidentiality agreement and the

12 case is not public yet.

13 Q. Any other reviews that you've conducted?

14 A. Well, it's been something that I've had to

15 look at from time to time in many instances. It's just

16 sort of part of the process of doing other -- doing the

17 variety of projects I've done related to health

18 insurance.

19 I would say that the issues that I'm referring

20 to here are always health insurance issues and any

21 restrictions that an ERISA plan document, which to me is

22 what I would review, has any specific restrictions or

23 limitations on the health insurer and whether or not

24 those restrictions have actually been met. Of course,

25 they're not always.

Page 47

1 Q. You refer to the clarity of communications

2 between payers and insureds. When you say communication

3 between payers and insureds, are you referring to EOBs?

4 A. Sometimes, but it also can be in benefit

5 packages, you know, benefit descriptions, EOBs, letters.

6 I mean, there's a variety of things, but EOBs are an

7 important component of it. But I would say more often

8 than not what my focus has been on is how the plan

9 documents have been interpreted as written in a benefit

10 booklet or a booklet that describes benefits.

11 Q. As you sit here today can you think of any

12 reviews that you have conducted regarding the clarity of

13 EOB communications between payers and insureds?

14 A. I would say that while it has been an issue in

15 a number of instances -- it's hard to specifically

16 remember cases, but, for example, earlier I mentioned

17 the work I did for Blue Cross Blue Shield. I've done

18 work on elements of claims processing, particularly fee

19 schedules, rates of payment, for a number of insurers,

20 and one of the issues that comes up in almost all of

21 those cases is how are limitations going to be

22 explained, limitations on payment or I guess primarily

23 the issue, how is that going to be explained to insureds

24 and what kind of a format. And ultimately it's the EOB,

25 but frequently the benefit booklet is important because

Page 48

1 it may -- a lot of benefit booklets will indicate that,

2 for example, if the participant uses a out-of-network

3 provider, that the out-of-network provider is going to

4 be paid at a usual, customary and reasonable rate

5 determined by the insurer. And one of the -- one of the

6 sticky factors that I've dealt with on several occasions

7 is whether or not that information is sufficient -- not

8 sufficient, but is clear, because the next sentence

9 usually says you may be responsible for the balance for

10 the out-of-network provider that was not covered by the

11 plan. And I've worked with a number of plans on a

12 description of usual, customary and reasonable in those

13 benefit booklets.

14 Q. Are you aware of any benefit booklets that

15 provide explanation regarding the remark codes that are

16 found in the EOBs?

17 A. No.

18 Q. Have you read the Court's order on the motion

19 for summary judgment in this case?

20 A. Yes.

21 Q. And do you dispute the Court's finding that

22 the remark codes at issue in this case are difficult to

23 understand?

24 MR. DEEGAN: Object to form.

25 THE WITNESS: Yes.

Page 49

1 BY MR. ZIPPERIAN:

2 Q. What's your basis for disagreeing with that

3 finding?

4 A. Well, I don't think that they're difficult to

5 understand.

6 Q. Well, we'll obviously get into that in much

7 more detail.

8 Other than your opinion, anything else that

9 you're relying on?

10 A. Well, that's kind of a binary question. I

11 don't know that -- well, yes, I would say that there are

12 other things besides my opinion. Most importantly, as I

13 indicate in my report, that the remark code descriptions

14 that the judge was referring to are industry standard

15 descriptions. So that is the way in which the industry

16 addresses those particular issues, and of course then my

17 research into remark codes identified that --

18 Q. Let me stop you right there, if you don't

19 mind, to get that specific point.

20 Do you believe that because they meet the

21 industry standard, that they're easy to understand?

22 A. No. No. What I'm saying is that the -- if I

23 remember your question correctly, what else did I rely

24 on other than my opinion, and what I relied on other

25 than my opinion is what the industry standard is, what

Page 50

1 other insurers use. That by itself does not necessarily
2 mean that they are understandable, but it does mean that
3 there's a large number of people who believe that they
4 are understandable.

5 Q. And those large number of people, are you
6 referring to people within the health insurance
7 industry?

8 A. Yes.

9 Q. What other insurers' remark codes did you
10 examine in preparation for your report?

11 A. I focused -- I focused on the four remark
12 codes that are included in the summary judgment. In the
13 course of reviewing remark codes, I reviewed the full
14 range of remark codes, but my focus was on the ones that
15 are in the case.

16 Q. Did you examine the remark codes that other
17 insurers use with the language other insurers use with
18 regards to the remark codes that are in issue in this
19 case?

20 A. Yes.

21 Q. Which insurers' remark codes did you examine?

22 A. I examined a range. As I indicate in my
23 report, I looked at the remark codes that CMS uses for
24 the Medicare program, which, of course, are quite
25 important, because what Medicare does is a lead for most

Page 51

1 insurers. They tend to follow Medicare. And, of
2 course, I looked at all the language in the remark codes
3 that are published or established by the X12
4 organization that I referenced, but I also looked at the
5 remark codes that Aetna uses and that CIGNA uses.
6 I found sample remark codes for a couple of
7 Blue Cross Blue Shield plans. I did a fairly
8 comprehensive search. And I don't remember all of them
9 that I looked at, but I did specifically look at Aetna
10 and CIGNA and compared them to United and CMS and X12
11 and compared them to United.

12 Q. Is the language that Aetna, CIGNA or
13 Blue Cross Blue Shield used in their remark codes
14 reflected in your report?

15 A. Well, the X12 and CMS are reflected in the
16 report. I've referenced I think in a footnote the Aetna
17 and CIGNA language, but I didn't write it up in the
18 report.

19 Q. Is there a reason why you didn't include
20 Blue Cross Blue Shield language in your report?

21 A. No. Other than since I was focused on United,
22 I was trying to identify language used by companies,
23 insurers, that are similar to United and Aetna, and
24 CIGNA fell into that category. The Blue Cross
25 Blue Shield plans I looked into were smaller and, you

Page 52

1 know, there's no particular reason that I didn't use
2 them other than I was just trying to provide the best
3 comparison.

4 Q. Other than those three insurers, did you
5 examine the language of remark codes used by any other
6 insurers, noting that you also looked at CMS and X12?

7 A. Well, I'm sure I did. I can't tell you, you
8 know, exactly which ones, because like I said, I did a
9 fairly comprehensive internet search, initially for EOBs
10 and then for lists of remark codes and I read several
11 but I didn't necessarily note who they were from.

12 Q. Those are searches you conducted using Google?

13 A. Google is a great tool. Yes.

14 Q. Going back to your report on page 1, it has
15 the scope of your assignment. And the first paragraph
16 under that section refers to August 21st, 2017 expert
17 report that you prepared in this case. Do you see that?

18 A. Em-hmm. I do.

19 Q. Are you still intending to offer an opinion on
20 the subject matter of your August 21st, 2017 report?

21 A. Well, I assume so. I mean, I have an opinion.
22 I have opinions that were expressed in that report.
23 Whether or not my opinions will be offered in the case
24 will be a decision made by the attorneys, but I assume
25 that I will.

Page 53

1 Q. Have any of your opinions stated in your
2 August 2017 report changed since the issuance of that
3 report?

4 A. No.

5 Q. And it says that your opinions in this report
6 are based on the research you completed as well as your
7 extensive experience in health insurance issues;
8 correct?

9 A. Yes.

10 Q. Are your opinions based on anything other than
11 those two things?

12 A. Well, the term research includes examination
13 of the documents that I received, so, in the broadest
14 context, it's just research.

15 Q. My understanding based on your previous
16 testimony is that you did not discuss the United
17 HealthCare claims denial process with anyone at United
18 HealthCare; is that correct?

19 A. That's correct. I did, of course, read the
20 declarations of United staff.

21 Q. And those are the declarations that were
22 submitted in this case?

23 A. Yes.

24 Q. Fairly recently?

25 A. Yes.

Page 54

1 Q. Other than your review of those declarations,
2 have you had any communications with anyone at United
3 HealthCare regarding their claims denial process or
4 remark codes?
5 A. No.
6 Q. Under the summary of your opinion, still on
7 page 2, you talk about industry standards. Do you see
8 that?
9 A. I do.
10 Q. What do you mean when you say industry
11 standards?
12 A. Well, industry standards is a term that's
13 normally used for what the generally accepted practice
14 is for doing something within a specific industry.
15 Q. And when you use the term industry standards,
16 what are you referring to? Specifically in this
17 context, the industry standards within the healthcare
18 industry, I'm assuming.
19 A. Within the health care industry and as it
20 specifically relates to remark codes.
21 Q. And in coming to define the industry standards
22 for the use of remark codes, other than the things we've
23 already discussed, the three insurers, the CMS and X12
24 data, did you review anything else?
25 A. Well, I indicated before I actually reviewed

Page 55

1 quite a few different sources online that included other
2 insurers. I would say I reviewed them more in passing
3 than selective, the ones that I've mentioned.
4 Q. You state that you opined that the codes at
5 issue are designed to provide sufficient information to
6 the members to initiate a dialogue regarding the claim
7 determination. Do you see that?
8 A. I do.
9 Q. What are the codes in issue in this case?
10 A. The codes at issue are the ones I've
11 identified. Well, and of course that the judge
12 identified in his summary judgment. But there are, if
13 you look at my Table 1, which starts on page 6, there's
14 the 13 code, the B5 code, the I5 code and the KM code.
15 Q. Those are the four codes at issue in this
16 case, to your understanding?
17 A. That's my understanding.
18 Q. How many remark codes do insurers use?
19 A. Hundreds.
20 Q. Do you know how many remark codes United
21 HealthCare uses?
22 A. Hundreds.
23 Q. I think I saw somewhere in your report that
24 the number can be in the thousands?
25 A. Could be.

Page 56

1 Q. Did you specifically ask United HealthCare how
2 many remark codes they use?
3 A. No.
4 Q. Do you know whether United HealthCare used any
5 codes other than the four codes that we've discussed in
6 relation to denying claims related to lactation
7 services?
8 A. I don't know. I didn't investigate that.
9 Q. Do you know if United HealthCare had a policy
10 related to claims related to lactation services and the
11 codes, the remark codes, that they used to deny those
12 claims?
13 A. I don't understand your question.
14 Q. Let me rephrase that.
15 Do you know if United HealthCare had a policy
16 that dictated which remark codes they used in relation
17 to denying claims for lactation services?
18 A. No.
19 Q. What's the purpose for insurers using remark
20 codes?
21 A. Well, to communicate to insureds and to
22 providers information about a claim that's been
23 submitted. Both the insured and the provider get
24 responses when they submit a claim, and frequently, but
25 certainly by no means not always, there are explanations

Page 57

1 that are required for describing how the claim was
2 treated. And the remark codes are used for that
3 purpose.
4 As is clear from any review that you would do
5 of standards, and X12 particularly, the advent of
6 electronic processing has made it necessary because of
7 the large volume of claims that are adjudicated or
8 processed by every insurer, that there needs to be some
9 standardization in responses, and that is what leads to
10 remark codes.
11 Q. Is part of the reason that insurers use remark
12 codes to streamline the claims processing system?
13 A. Well, sure.
14 Q. And is part of the reason they use those codes
15 to eliminate as much as possible individual inquiries
16 into claims?
17 A. No.
18 Q. What's your basis for saying that that's not
19 one of the reasons?
20 A. Well, if you look at an EOB, the EOB not only
21 provides a remark code, but provides sort of multiple
22 discussions of how an insured can address any issues
23 they have with the explanation of benefits. The EOB
24 identifies who they should call, who they can write to,
25 that they can make an appeal. I don't think that if

Page 58

1 they were trying to reduce the number of questions or
2 responses to remark codes, that they would have a reason
3 for including all that information.
4 Q. But isn't that language the same for every
5 EOB? Isn't it standardized language?
6 A. Yes.
7 Q. I think we might be talking about different
8 things when we say individualized inquiry or at least in
9 this particular area. I'm saying that isn't one of the
10 reasons that health insurers use remark codes so that
11 they can use standardized processes to deny claims?
12 A. Well, they can use standardized processes, I
13 wouldn't say specifically to deny claims, because in a
14 lot of instances the remark codes don't necessarily
15 relate directly to a denial. You know, a remark code
16 may say we need more information so that -- you know, if
17 you're asking the question of are remark codes used to
18 provide explanations that will result perhaps in fewer
19 inquiries, that's their purpose. That's why they exist.
20 I mean, they exist because of the insurer's desire to
21 provide information back to the insured in the case of
22 EOBs or to a provider as to what their reasoning is as
23 it relates to a specific claim.
24 Q. There's a couple things I want to ask you
25 about in that response. First one is: Don't the remark

Page 59

1 codes allow the insurers to use standardized language to
2 provide information to the insureds?
3 A. Yes.
4 Q. And then you referenced a request for more
5 information as a nondenial purpose for an EOB; correct?
6 A. Yes.
7 Q. Isn't it correct to say that the EOB is a
8 denial unless there's additional information provided?
9 A. Well, it doesn't always say that.
10 Technically, I think any time a remark code is used,
11 it's an explanation of why the claim has not been paid
12 as submitted. I don't -- to me that's not a denial. I
13 mean, maybe other people -- it's just a use of language.
14 Other people may look at that and say it's a denial.
15 To me, a denial occurs at the end of the
16 process when the insurer determines they are not going
17 to pay that claim. So, obviously, if you have a request
18 for more information, I think anybody would assume that
19 if that information isn't submitted, a denial is highly
20 possible, highly probable, but it doesn't say that.
21 Actually, there are some remark codes that do say it,
22 but generally not necessarily so.
23 Q. But if you get an EOB that contains a request
24 for more information and you don't give more
25 information, will your claim be paid?

Page 60

1 A. Probably not. But I think that it's important
2 to keep in mind that all of these situations, every
3 insured situation is individual. You know, so that I
4 have certainly seen instances where the additional
5 information was not provided and that in the course of
6 the total adjudication of the claim and communication
7 with the individual insured, the insurer determined that
8 it was okay to pay the claim. I mean, so it isn't
9 automatic by any means. It's definitely based upon the
10 individual circumstances.
11 Q. Can you think of an instance in which an
12 insured received an EOB requesting more information and
13 the insured took no further steps and the claim was
14 paid?
15 A. I certainly couldn't name an insured for you
16 without -- where that took place, but I can tell you
17 that in my working with health insurers, I've come
18 across such instances but without any knowledge of those
19 specific insureds that was involved.
20 Q. What healthcare plan are you referring to in
21 that?
22 A. A recent case that I've worked on that
23 involved Blue Cross Blue Shield of Texas that comes to
24 mind where the claim was paid but despite the fact that
25 the additional information was not submitted. Actually,

Page 61

1 several of the claims that are involved in a case that
2 I'm working on had the claim paid despite the lack of
3 information of a certain type.
4 I think, as I said before, it's you have to
5 think of the overall situation and environment in which
6 claims are paid.
7 Every effort is made by an insurance company
8 to standardize and automate the process, but once a
9 remark code is issued and in response to that an insured
10 raises a question, then the process becomes
11 individualized as it relates to that insured, and the
12 specific requirements of the insured are considered and
13 specific decisions are made as it relates to that
14 insured's situation and that includes a lot of
15 communication directly between the insured and plan
16 representative. And it may result, just in my
17 experience, it may result in payment regardless of the
18 fact that the additional information hasn't been
19 submitted.
20 Now, if the additional information is
21 submitted and there's no contact, then it's highly
22 likely that the claim will be denied, but if there's
23 contact, which is typically the case when an insured
24 raises a question otherwise.
25 Q. Do health plans, in your experience, have

Page 62

1 standardized processes by which they respond to
2 insureds' inquiries about claims denials?
3 A. Yes.
4 Q. Do those standardized processes include
5 scripts for telephone calls?
6 A. Yes.
7 Q. Are you aware of United HealthCare using any
8 standardized processes for responding to insureds'
9 inquiries about claims denials?
10 A. No, I'm not -- I don't -- I'm not
11 knowledgeable about exactly how United HealthCare
12 approaches that. I'm speaking from my experience with
13 other insurers.
14 Q. Do you know whether they have standardized
15 processes?
16 A. I assume that they do.
17 Q. That's not something you asked anyone at
18 United HealthCare?
19 A. No. It wasn't relevant to my opinions.
20 Q. Is whether a particular remark code is
21 appropriate or inappropriate relevant to whether the
22 code is difficult for an insured to understand?
23 A. I think I used the words inappropriate or
24 appropriate in my report, and what I was referring to
25 was something else. I was referring to whether or not

Page 63

1 it was the right code to be used for that specific
2 circumstances. It didn't necessarily -- my use of those
3 words didn't necessarily relate to whether it was
4 understandable.
5 Q. And do you think that there is a relationship
6 between whether the right code is used and whether that
7 makes it easy to understand for an insured?
8 A. It -- well, that depends on the code. I mean,
9 the fact that it's the right or the wrong code doesn't
10 actually necessarily have a direct effect on the
11 understandability. It may, but not necessarily.
12 Q. How would whether it's the right code affect
13 its understandability?
14 A. Well, I think that's you that's saying it
15 affects the understandability. I'm not saying that it
16 does. I'm saying it might.
17 Q. And I'm asking how might it?
18 A. Well, if one code -- if a code was used that
19 did not relate correctly to the insured's situation,
20 certainly that's going to be hard for the insured to
21 understand why that -- what's being said there. So I'm
22 not talking about the language in the code. I'm just
23 talking about the fact that unless you have the right
24 code, it's going to be difficult for somebody to
25 understand why that code was selected or what that's

Page 64

1 supposed to mean, but that's independent of the
2 language.
3 Q. Do you think the typical insured knows what a
4 CPT or HCPCS code is?
5 A. Probably not.
6 Q. Do you think the typical insured knows what
7 the term modifier or modifier combination is in the
8 context of receiving an EOB?
9 A. No, but I do believe that the description --
10 we are talking about the description for the KM code. I
11 do believe that the description for that code does
12 provide sufficient communication for the insured to
13 understand what needs to be done.
14 You don't have to know what all the CPT codes
15 or HCPCS codes or modifiers are to understand. The
16 wording there indicates that, you know, perhaps the
17 wrong code was used, and that's a provider issue. And,
18 to me, I think anybody receiving that would contact
19 their provider or they might contact United and say what
20 does that mean, and United would say to contact your
21 provider. But I think that it's clear that -- what the
22 code is intended to mean, and I don't think you need to
23 know what CPT and HCPCS mean in order to understand
24 that.
25 Q. Why do you think anyone receiving that code

Page 65

1 would know that they should contact United HealthCare or
2 their provider about their denial?
3 A. Well, while most people don't necessarily know
4 the specifics of CPT and HCPCS codes, they know that
5 their claims -- their claims that are submitted use
6 codes and that the wording that is used, to me,
7 reflects -- it would leave me -- assuming I did not --
8 had never heard of CPT or HCPCS codes or modifiers, it
9 would leave me with the understanding, well, wait,
10 something was wrong on my claim and if that -- to me
11 that means that you initiate communication. And, in
12 fact, that frequently occurs.
13 Q. When we're talking about you, we're talking
14 about someone with 45 years in the healthcare industry?
15 A. I was using me absent that knowledge. Say,
16 for example, my wife.
17 Q. Still talking about an educated person; right?
18 A. Well, I think a person of reasonable
19 intelligence.
20 Q. You said in your response, I think, and
21 correct me if I'm wrong, that people know that codes are
22 used in their claims. Is that --
23 A. I did say that.
24 Q. What's your basis for believing that?
25 A. Just my experience and my experience in

Page 66

1 dealing with people because of my -- I mean, this is --
2 I guess this is as specific a response as I can provide
3 to you on this. Because of what I do and the fact that
4 it is known among friends and family, I frequently get
5 questions when somebody gets an EOB as to what something
6 means or other aspects of health insurance, and at least
7 the people that I talk to have no experience with the
8 healthcare system.

9 Understand that when claims are submitted,
10 there's a description of the service that is provided
11 and most people have seen claims and recognize that
12 there are codes listed on the claims.

13 Q. Other than your anecdotal knowledge with
14 regards to friends and family, do you have any other
15 basis for believing that the typical insured knows that
16 codes are used in their claims?

17 A. No, but I think that we have to -- I have to,
18 in responding to your question, recognize that there's
19 more to the remark description than just CPT and HCPCS
20 codes. The remark description begins with this is not a
21 reimbursable service and then it indicates that another
22 code might be more appropriate. I think that is --
23 whether or not you know, an individual knows that codes
24 are used, reading that, they should understand that
25 codes are used and they should also understand that

Page 67

1 whatever code was submitted is not a reimbursable
2 service. That's what it says. I don't expect that
3 people are going to have knowledge of the CPT and HCPCS
4 system.

5 Q. And we'll get into the specific language of
6 each of the codes as we move forward, which I know you
7 can't wait for, but going back to page 4, in the last
8 paragraph, the last sentence, you state:

9 "ERISA includes regulations that state
10 generally that remarks associated with denials
11 on EOBs should be understandable from the
12 perspective of an insured but also do not
13 provide specific remark code descriptions."

14 Do you see that?

15 A. Yes.

16 Q. What ERISA regulations are you referring to
17 there?

18 A. I couldn't quote them for you precisely.
19 Actually, more than anything, I was referring to the
20 summary judgment order in which the judge used that
21 language.

22 Q. Okay. You also state that:

23 "Remark codes are designed to be easily
24 understandable by insureds."
25 Is that right?

Page 68

1 A. Yes. That's the intent, yes.

2 Q. What's your basis for saying that the codes
3 are intended to be easily understandable by insureds?

4 A. Well, aside from it being I think sort of
5 obvious that that's an intent, as I indicated in my
6 tables in this report, I include the language from X12
7 and from CMS that relates to specific -- the specific
8 remark codes in question. And I think that you can see
9 that in this case United has made an effort to put that
10 language into sort of outside of sort of IT speak and
11 into English as best as they possibly can. And if you
12 can look at the EOBs of other insurers as well, you will
13 see that they make the effort to interpret those codes,
14 which are the standard codes in the industry, in such a
15 way that people can understand them.

16 Q. Did you speak with anyone at United HealthCare
17 regarding the design of the remark codes?

18 A. No.

19 Q. Did you speak with anyone at United HealthCare
20 regarding the intent behind the design of the remark
21 codes?

22 A. No.

23 Q. On page 4 you state in the first full
24 paragraph:
25 "The remark codes communicate

Page 69

1 information about payment, reasons for denials,
2 missing information, et cetera. Members
3 typically receive remark codes on their EOBs
4 that the health plan sends to the member to
5 explain how the claim their provider submitted
6 for reimbursement was processed."

7 Do you see that?

8 A. Yes.

9 Q. Then you give an example of an I5 remark code
10 that Jance Hoy received. Do you see that?

11 A. Yes.

12 Q. And that says:
13 "This service is not separately
14 reimbursable in this setting."
15 Do you see that?

16 A. I do.

17 Q. Does that mean that the claim was denied in
18 part or in full?

19 A. Well, at this -- at this point it was denied
20 in full.

21 Q. And how do you know that looking at the remark
22 code?

23 A. Looking specifically at the remark code? I'm
24 looking at the overall EOB to see that the claim was not
25 paid. To me, the way the EOB reads is an indication the

Page 70

1 claim was not paid and then the remark code is not
2 intended to separately indicate that the claim was not
3 paid. That's already been said. It's intended to
4 provide a reason for that. And the reason is that the
5 specific code used was not reimbursable separately in
6 this setting.

7 Q. And you believe that the combination of those
8 two things makes it clear that that's the case, that the
9 claim is denied, was denied in full?

10 A. Well, yeah. I think that when it says your
11 plan paid zero, that's a pretty good indication that the
12 claim was denied. I think it's important to remember
13 that language that then covers a lot of the rest of the
14 EOB that says if you have questions, you've got people
15 to call, you can call your provider, you can submit an
16 appeal, but it seems to me that it's pretty clear when
17 the EOB says your plan paid zero, that the claim was
18 denied.

19 Q. And in your opinion is the remark code --
20 strike that.

21 In your opinion is the purpose of the remark
22 code to communicate the reason for denial to a member or
23 to initiate a dialogue between the member and the plan?

24 A. Well, both. Look, it certainly provides a
25 reason, but the EOB as a whole is intended to provide a

Page 71

1 foundation for communication.

2 Q. What percentage of claims submitted to health
3 insurers are denied?

4 MR. DEEGAN: Object to form.

5 THE WITNESS: Overall? I have no idea.

6 BY MR. ZIPPERIAN:

7 Q. Are you familiar with the Department of Labor
8 study that indicates that one in seven claims is denied?

9 A. I'm not familiar with the study, but I think
10 that that's certainly a reasonable number. Not being
11 familiar with the study, I don't know what they mean,
12 that they were ultimately denied or initially denied.
13 And, of course, there are many reasons for denial.
14 Frequently, a claim is denied because the claim included
15 a service that was not covered. And there's also the
16 issue of how do you define a claim.

17 You know, this particular claim that we're
18 looking at had one instance of service. There are many
19 claims, certainly claims for hospitals and in many
20 instances physicians include several different lines on
21 the claim and the claim may be paid in part but one line
22 on the claim, one service, may have been denied. So I
23 don't know how those denials would count -- were
24 counted.

25 Q. All right. How does the example that you have

Page 72

1 on page 4 here for Jance Hoy communicate the reason for
2 the denial of her claim?

3 A. The language refers to a service code and, to
4 me, the indication is that the specific service that was
5 provided can be paid in some settings but in the setting
6 in which it was provided to Ms. Hoy, it's not.

7 Q. And you believe that a typical insured would
8 have the same understanding that you do in reading that
9 remark code?

10 A. Yes, I think so.

11 Q. So correct me if I'm wrong here, but it sounds
12 like, in terms of initiating a dialogue, your opinion is
13 not necessarily that the remark code itself initiates a
14 dialogue, but that taken in conjunction with the
15 entirety of the EOB, those things combined initiate a
16 dialogue between the insured and the health plan? Is
17 that right?

18 A. Not quite. I think that the remark code --
19 what you are saying is correct. It's the entire EOB
20 that initiates the dialogue, but the remark code will be
21 the subject of that dialogue.

22 Q. So is there something about the I5 remark code
23 that by itself, absent the rest of the EOB, that acts to
24 initiate a dialogue between the insured and the insurer?

25 MR. DEEGAN: Object to form.

Page 73

1 THE WITNESS: I think that's -- that's kind
2 of an individualized response. I think that there are
3 some insureds that will immediately see that as a
4 reason for a dialogue because it says it's not
5 separately reimbursable in this setting. And I think
6 there are a lot of insureds that would then say, well,
7 what do you mean, why not? And that would initiate --
8 it should lead to the initiation of a dialogue. There
9 are others that may say, well, okay. Each person is
10 going to respond differently.

11 BY MR. ZIPPERIAN:

12 Q. And that is not exactly what I'm asking. I
13 think what you're saying is an insured might get a
14 denial and see the remark code and think I'm going to
15 contact them because I got a denial?

16 A. No. I'm saying as it directly relates to the
17 language in the remark code.

18 Q. But is there something in the language of the
19 remark code that says contact your insurer or even
20 insinuates that?

21 A. No, but I don't think that that's necessary,
22 because in the next few paragraphs it says to contact
23 the insurer.

24 Q. And when you say the next few paragraphs, you
25 are talking about the EOB generally?

Page 74

1 A. Correct. I think it's important that the
2 insured doesn't receive the information that's presented
3 in my report alone. You know, that's not the sole
4 information that they receive. It's in the context of
5 the EOB.
6 Q. Do providers also receive EOBs?
7 A. Yes.
8 Q. Do they receive the same EOBs?
9 A. Depends on the insurer, but, no, not exactly
10 the same.
11 Q. In the context of United HealthCare, what
12 differences are there between the EOBs received by the
13 provider and the insured?
14 A. I don't know. I didn't specifically look into
15 that as far as United goes. They received the same
16 information, but whether or not the actual format is
17 exactly the same is not something that I looked into.
18 Q. When you say the same information, are you
19 talking about the same service codes or remark codes?
20 A. The same service codes, the same information
21 about who the patient was and if there was a denial or
22 if there was some other remark. They receive all that
23 information, but in addition to that, they may receive
24 additional information.
25 Q. Going back to the example on page 4, does the

Page 75

1 remark code communicate the reason for the denial to an
2 insured?
3 A. I think so. You know, it says it's not
4 separately reimbursable in this setting.
5 Q. What does the term separately reimbursable
6 mean?
7 A. Well, it means that in some instances the
8 service that was provided is bundled together with other
9 services and it is not separately reimbursed. In other
10 instances it could be, if it's the sole service
11 provided, it could be separately reimbursed, but what
12 this indicates is this particular setting in which it
13 was provided is not reimbursed.
14 Q. And what does the term setting mean in this
15 context?
16 A. The location in which the service was
17 provided.
18 Q. And you think those terms are easily
19 understandable by a typical insured?
20 A. Well, I do, but I also think that if the
21 insured does not understand that, that they're given
22 plenty of direction on who to call.
23 Q. And that direction comes from the EOBs?
24 A. Correct.
25 Q. Turn to page 5. And in the first paragraph

Page 76

1 there on page 5, you state:
2 "In my experience, major health plans,
3 including UHG, seek to align their codes with
4 the structures established by national
5 organizations or entities such as the Centers
6 for Medicare and Medicaid Services, CMS, X12
7 organization and the industry standards set by
8 CORE Code Combination."
9 Do you see that?
10 A. I do.
11 Q. What specific health plans are you referring
12 to that seek to align their codes with the CMS?
13 A. All of the health plans that I've worked with.
14 Q. And you include United HealthCare in that
15 group?
16 A. Yes.
17 Q. What is your basis for your understanding that
18 United HealthCare has sought to align their codes with
19 the structures established by CMS, X12 and CORE Code
20 Combination?
21 A. Well, aside from the fact that most insurers
22 recognize that both CMS and X12, as well as the CORE
23 group, but mostly CMS and X12, put a lot of effort into
24 identifying remark codes and, therefore, the insurer has
25 the choice of either using remark codes as developed,

Page 77

1 because with all the resources that those organizations
2 apply or try to create their own -- and in my experience
3 the insurers don't do that, they don't try to create
4 their own -- when recognizing that the purpose behind
5 the X12 and CMS codes is to provide leadership for the
6 industry, but the other thing, too, is that there is --
7 one of the declarations from United was -- I think it's
8 Nina Thompson's declaration, in which she describes the
9 process by which United develops its codes, and she
10 talks specifically about mapping their codes to the CMS
11 and X12 codes.
12 Q. What does the term code mapping mean to you?
13 A. Well, to me it means that you have two sets of
14 descriptions and you are trying to determine whether or
15 not they are comparable in one or more comparisons. I
16 think it's a -- it's not a term that it literally means
17 drawing a map. Maybe code matching would be a better
18 term.
19 MR. ZIPPERIAN: All right. Why don't we take
20 five minutes.
21 THE VIDEOGRAPHER: This ends Media 2 in the
22 deposition of Dr. Henry Miller. We are off the record
23 at 11:12 a.m.
24 (Recess held.)
25 THE VIDEOGRAPHER: This begins Media 3 in the

Page 78

1 deposition of Dr. Henry Miller. We are on the record
2 at 11:22 a.m.
3 MR. ZIPPERIAN: Let's go ahead and mark this
4 as Exhibit Miller 2.
5 (Exhibit 2 was marked for identification.)
6 BY MR. ZIPPERIAN:
7 Q. Dr. Miller, can you tell me what Exhibit 2 is?
8 A. It is the explanation of benefits for Jance
9 Hoy dated December 22nd, 2015.
10 MR. ZIPPERIAN: And, for the record, it's
11 Bates-numbered UHC000873 through 876.
12 Q. Where in Miller 2 does it explain how
13 Ms. Hoy's claim was processed?
14 A. Well, it explains it throughout. The first
15 page is a summary. That summary shows that the amount
16 that was billed with an explanation, total amount the
17 provider billed for the service, and then it indicates
18 that there was a discount on that price which United
19 negotiated. And then the third item is how much the
20 plan paid. And then it says how much you owe. So I
21 think that it's a summary, but it's a pretty clear
22 indication of how the claim was processed.
23 Q. What do you mean when you say how the claim
24 was processed?
25 A. What was the disposition of the claim. And

Page 79

1 then, of course, the rest of the EOB provides more
2 detail on those particular points.
3 Q. Let's look at the notes and the remark code.
4 That's a KM code. Do you see that?
5 A. Yes.
6 Q. It says:
7 "This is not a reimbursable service.
8 There may be a more appropriate CPT or HCPCS
9 code that describes the service and/or the use
10 of the modifier or modifier combination is
11 inappropriate."
12 Do you see that?
13 A. Yes.
14 Q. And do you think that that language is easily
15 understandable to a typical insured to explain why her
16 claim was denied?
17 A. You know, one of the things -- and we've been
18 discussing this issue and I've already answered it, I
19 thought that this was understandable, this particular
20 language, but I think at least I recognize that
21 understandability is a pretty subjective term. So when
22 I say I think so, yeah, but I cannot really measure
23 understandability.
24 What I do think here is that this is a clear
25 communication that identifies the issue. And, you know,

Page 80

1 then as I indicated before, there's a series of remarks
2 that give you -- give the insured the information that
3 they need to appeal, to ask questions, to -- and right
4 at the top of the second page, in the right-hand corner
5 it specifically says:
6 "Have more questions about your claim?
7 Visit website for all your claim and benefit
8 information."
9 So I think that, yes. Again, I can't tell you
10 if Jance Hoy understood, because that's sort of an
11 individualized issue, but I can tell you that there is
12 effective communication in that code as well as in the
13 rest of the EOB that gives Jance Hoy the opportunity to
14 find out more.
15 Q. And how would a patient learn more about a
16 remark code?
17 A. Well, there are a number of -- well, not a
18 number. There are at least a couple of different ways.
19 As I indicated, there on the upper right-hand corner of
20 this form, it says, "You have more questions" -- that
21 includes the remark code, you know, the questions that
22 you may have, and identifies the website that you can --
23 you can visit to get more information, but there's also
24 a phone number there and you can call.
25 Q. Let's take those separately. Have you visited

Page 81

1 the myuhc.com website?
2 A. Yes.
3 Q. And is there information on that website
4 regarding remark codes?
5 A. Well, what I don't -- not specifically in a
6 general sense, because it's intended to be a
7 personalized website for people who are enrolled in the
8 United plan and you have the opportunity to enter in
9 your personal identification information, and I couldn't
10 do that, so I couldn't get down to that level.
11 Q. So is it fair to say that you don't know if
12 going to myuhc.com would provide a member additional
13 information on their remark codes?
14 A. I can't, because I can't look at an
15 individual -- an individual's information.
16 Q. Do you know if there's a specific department
17 at United Health that is tasked with maintaining the
18 information on the myuhc.com website?
19 A. No. I imagine there is, but, no, I don't know
20 that.
21 Q. With regards to the telephone number, did you
22 call that phone number?
23 A. No.
24 Q. Do you know what information they provide on
25 that phone number with regards to remark codes?

Page 82

1 A. No.
2 Q. Do you know if there's a specific department
3 at United Health that's tasked with responding to
4 questions about remark codes?
5 A. No.
6 Q. Do you know if there's a source document that
7 dictates how people answering the phone are to respond
8 to inquiries about remark codes?
9 A. No.
10 Q. In your report you make the statement that:
11 "The EOB is designed to provide
12 information about how a claim was processed and
13 then sets forth means by which members and
14 providers can contact the health plan for more
15 information, including information regarding
16 diagnostic and treatment codes used in the
17 claims determination."
18 Do you see that?
19 A. Yes.
20 Q. And then you have a footnote there that you
21 cite to and you have a number of different things listed
22 in that footnote I presume that you think support that
23 proposition; is that right?
24 A. Yes.
25 MR. ZIPPERIAN: Let's go ahead and mark those

Page 83

1 as exhibits.
2 MR. DEEGAN: Which footnote?
3 MR. ZIPPERIAN: It's Footnote 15. So this
4 first one will be Miller No. 3. This will be Miller
5 No. 4. This will be Miller No. 5. Miller No. 6.
6 Miller No. 7. Miller No. 8. All right.
7 (Exhibits 3 through 8 were marked
8 for identification.)
9 BY MR. ZIPPERIAN:
10 Q. Dr. Miller, I would like to go through those
11 individually. The first one is a website that you cite
12 to, Footnote 15, uhc.com/content. I'm not going to read
13 the whole thing. It takes you to what looks like a
14 "viewing your EOB" website. Do you see that?
15 A. I do.
16 Q. How did you find this website?
17 A. I entered a search for United HealthCare EOB
18 and what information might be available.
19 Q. And is that a Google search?
20 A. Yes.
21 Q. And this came up?
22 A. Yes.
23 Q. And in Footnote 15 you say, in parens:
24 "Providing information on how the EOB is
25 structured and demonstrating that the EOB

Page 84

1 contains a phone number for members to call for
2 more information."
3 Do you see that?
4 A. I do.
5 Q. The phone number that you're referring to, is
6 that the 1 (888) 888-8888 number?
7 A. Yes.
8 Q. That's not a real phone number, as far as you
9 know, is it?
10 A. No. This is a sample EOB.
11 Q. Is it your testimony that a remark code is
12 intended to serve as sufficient explanation for the
13 reason for a denial?
14 MR. DEEGAN: Object. Objection. Form.
15 THE WITNESS: I would say that the remark
16 code is -- it depends. The answer is it depends. At
17 times it can be sufficient.
18 But the reason why EOBs identify places that
19 you can go to, websites or phone numbers regarding
20 questions, is in case any element of the EOB is
21 questionable. So, you know sometimes remark codes are
22 sufficient to make it clear, sometimes they're not, but
23 in all instances, the opportunity for the person
24 receiving the EOB to know where to call or where to look
25 for more information is clear.

Page 85

1 BY MR. ZIPPERIAN:
2 Q. And when you say it's clear, you're referring
3 at least in part to the line on the sample EOB that
4 says, "have more questions about your claim," question
5 mark, and then says "visit" with the name of a member
6 website. Is that accurate?
7 A. Yes. As well as on the other side of that
8 portion of the EOB, the phone number of the processing
9 service center.
10 Q. Is there anything in the EOB that says this is
11 not a final claim determination but the beginning of a
12 dialogue between you and your plan, if you disagree with
13 our claim decision, call us or contact us at or
14 something along those lines?
15 A. Are you asking specifically as it relates to
16 this exhibit?
17 Q. This exhibit or any EOB. But I guess we
18 should probably make the question about this particular
19 sample exhibit.
20 A. Well, it's not in this particular example,
21 which, you know, I was using this example to support the
22 sentence that you read earlier, my experience with major
23 health plans, including -- I'm sorry -- supporting the
24 point that the EOB is designed to provide information
25 about how a claim was processed and then sets forth the

Page 86

1 means by which members and providers can contact the
2 health plan for more information, and that's what this
3 does.
4 Q. If the design of the EOB was to initiate a
5 dialogue between the insured and the insurer, as I
6 believe you've testified to, why doesn't the EOB say
7 that specifically?
8 A. I think it does. I think when you have right
9 at the top of the key page describing presenting the
10 EOB, it says, "you have more questions," do this. I
11 think that's -- that's where the indication is that the
12 dialogue is going to begin.
13 Q. Is there anywhere on the sample EOB that
14 indicates that the EOB is not a final determination of
15 the claim?
16 A. On the sample one, no.
17 Q. Is there anything that specifically indicates
18 that the EOB is intended to be the initiation of a
19 dialogue between the insured and the insurers?
20 A. Well, as I said, the "more questions about
21 your claim," to me, is an initiation, an opportunity to
22 initiate a dialogue.
23 MR. ZIPPERIAN: Let's go ahead and mark this
24 as Miller 9.
25 MR. DEEGAN: Are we setting 3 aside or using

Page 87

1 them simultaneous?
2 MR. ZIPPERIAN: Maybe, but probably not.
3 (Exhibit 9 was marked for identification.)
4 BY MR. ZIPPERIAN:
5 Q. Miller 9 is a printout of the myuhc website
6 log-in page. Do you see that?
7 A. I do.
8 Q. And I know I asked you this before, but I
9 don't remember your response. Have you looked at this
10 website before, even this page?
11 A. This page. That's as far as I've gone.
12 Q. Is there anything on this page that indicates
13 where a member would find out more information about
14 their EOB?
15 A. No. It doesn't relate specifically to a
16 member's EOB. This is the page where the member would
17 sign in and then more information would become
18 available.
19 Q. It does have a common questions section on the
20 far right. Do you see that?
21 A. Em-hmm.
22 Q. And it has a section in the middle that says
23 "learn more about" and has a number of different things
24 under that. Do you see that?
25 A. Em-hmm.

Page 88

1 Q. Do either of those sections reference EOBs or
2 remark codes?
3 A. No. I don't think that's the purpose of this
4 page.
5 Q. What do you think the purpose of this page is?
6 A. It's just -- it's the sign-in page that if you
7 want to get information from the website, you need to
8 sign in. And the rest of it is just an effort by United
9 to answer questions that have come up frequently and
10 just provide information on the use of the website.
11 It's not intended to have more than that.
12 Q. Do you think questions about the reasons for
13 claims denials is something that would come up
14 frequently?
15 MR. DEEGAN: Object to form.
16 THE WITNESS: Yes, I do.
17 BY MR. ZIPPERIAN:
18 Q. This does allow members the opportunity to
19 learn more about, for instance, health insurance for
20 those not covered by employer, short-term health
21 insurance, health savings accounts. Do you see that?
22 A. Yes.
23 Q. But no information on this page about EOBs or
24 remark codes; correct?
25 A. No, but this is -- this is the sign-in page

Page 89

1 for a more -- a considerably more complex website.
2 Q. Have you visited the considerably more complex
3 website?
4 A. No. I've already indicated that you can't do
5 that unless you sign in with a user name and a password,
6 and I'm not a United customer.
7 Q. You are assuming that it's considerably more
8 complicated, but you've not seen it?
9 A. I am assuming it based upon my experience with
10 other insurers where I do have the opportunity to access
11 that information.
12 Q. Going back to Footnote 15, you list a CIGNA
13 website. What's the purpose for listing that?
14 A. Well, again, the footnote relates to the
15 sentence that says:
16 "EOB is designed to provide information
17 about how a claim is processed and then sets
18 forth the means by which members and providers
19 can contact the health plan for more
20 information."
21 And the reference to the CIGNA website, that's
22 one of the -- another source in addition to United that
23 provides that information.
24 Q. Is that relevant to what information is
25 provided in the United HealthCare EOB?

Page 90

1 A. No. I was talking in my report in this
2 particular paragraph about EOBs in general.
3 Q. Okay. Let's take a look at Miller No. 4,
4 which has been previously marked as Hoy 110. This is
5 not an EOB; is that right?
6 A. Correct.
7 Q. It's information that was provided to Hoy by
8 her provider? Is that your understanding?
9 A. Yes.
10 Q. It's not information that was provided by
11 United Health; right?
12 A. That's correct.
13 Q. And do you think it's the provider's
14 responsibility to provide information to United
15 HealthCare members regarding how they should handle
16 their claims with regard to United HealthCare?
17 A. Whether or not it's their responsibility is
18 something that an individual provider has to decide.
19 And many providers do decide to provide such
20 information. And when they provide it, I assume they
21 consider it to be their responsibility to do that, but
22 there's nothing that requires them to do that.
23 Q. Why do you think the providers provide
24 information to their patients regarding how they should
25 handle their claim with United HealthCare or other

Page 91

1 insurers?
2 A. Because they want to be paid and they want to
3 have their patients benefit from the experience that
4 they've had in dealing with insurers.
5 Q. And in your experience is it common practice
6 for providers to provide information similar to that
7 contained in Miller No. 4 to their patients?
8 A. Well, I think I already answered that some
9 providers do and it's not unusual. I can't really speak
10 to a percentage of providers that do it.
11 Q. If the information in an EOB and in the remark
12 code in an EOB was clear in articulating the reason why
13 a claim was denied and the process by which a patient
14 should get more information, why would a provider feel
15 the need to provide this information to their patients?
16 MR. DEEGAN: Object to form.
17 THE WITNESS: I can't answer that. This
18 Breastfeeding Resource Center's
19 believed that it was important to do it, but I
20 don't know -- I can't tell you why.
21 BY MR. ZIPPERIAN:
22 Q. Let's take a look at Miller 5. Miller 5, 6, 7
23 and 8 are all EOBs. Can we agree to that?
24 A. Yes.
25 Q. And they are EOBs for Jance Hoy, Christine

Page 92

1 Endicott and Felicity Barber, some of the plaintiffs in
2 this case; correct?
3 A. Correct.
4 Q. Taking a look at just at 5, how does the EOB
5 provide information on how to contact United HealthCare
6 about an appeal?
7 A. Well, it's presented immediately following the
8 notes to the EOB. So in the case of the first exhibit
9 for Jance Hoy, for the first paragraph following the
10 notes is an indication of how to submit an appeal.
11 Q. And the process for submitting an appeal is
12 mailing a request to a P.O. box in Salt Lake City; is
13 that right?
14 A. Correct.
15 Q. Does this provide any information as to the
16 form that that appeal should take?
17 A. No.
18 Q. Is there a reason why it doesn't do that?
19 MR. DEEGAN: Object to form.
20 BY MR. ZIPPERIAN:
21 Q. As far as you know?
22 A. Well, no. It doesn't provide that
23 information. My experience is that appeals can be
24 submitted for a great many reasons and the health
25 insurers at the time that the appeal is submitted,

Page 93

1 health insurers begin an individualized process with
2 each person submitting the appeal and the format for the
3 submission is not -- doesn't -- there's no reason for it
4 to be uniform.
5 Q. Is there a reason, as far as you know, why the
6 only means of implementing or starting an appeal is by
7 mailing it to United HealthCare?
8 MR. DEEGAN: Object to form.
9 THE WITNESS: No. Could you repeat your
10 question.
11 BY MR. ZIPPERIAN:
12 Q. Let me rephrase it.
13 This EOB, Miller 5, indicates that the only
14 option for starting the appeal process is to mail
15 something to a P.O. box in Salt Lake City. Is that
16 accurate?
17 A. That's the instruction that's given here, but,
18 of course, there is also the indication on the top of
19 every page of the EOB that you can address questions
20 about your claim on the website as well.
21 Q. Is there anything in the EOB that indicates
22 that you can submit an appeal online?
23 A. No.
24 Q. Is there anything in the EOB that indicates
25 that you can submit an appeal over the phone?

Page 94

1 A. No. You can call and ask questions, but you
2 would have to submit an appeal in writing. I think
3 that's, in my experience, universal throughout the
4 health insurance industry because you want to get the
5 documentation as it is specifically provided by the
6 insured.

7 Q. What documentation?

8 A. The documentation that describes what the
9 issue is.

10 Q. How would the insured know what documentation
11 to submit based on their receipt of the EOB?

12 A. I'm not -- I used the term documentation. I
13 probably should have used the term explanation, that the
14 reason for an appeal can easily vary from one insured to
15 the next and the nature of an appeal is an
16 individualized concern.

17 And if you are going to appeal, you don't -- I
18 can't imagine somebody would just say I appeal. You
19 know, they are going to provide some explanation as to
20 what their concern is or what the problem is. At least
21 that's the way I've always seen it happen.

22 Q. Is there a reason why that couldn't be done
23 online?

24 MR. DEEGAN: Object to form.

25 THE WITNESS: Whether there's a technical

Page 95

1 reason? I don't think there's a technical reason, but
2 whatever the reason is, every insurer that I'm familiar
3 with requires it in writing and not online. It could
4 be done online, certainly.

5 BY MR. ZIPPERIAN:

6 Q. In your experience have you had discussions
7 with insurers about allowing insureds to submit appeals
8 online?

9 A. No.

10 Q. What about over the phone?

11 A. I haven't had discussions about it, but I
12 think that it's obvious that submitting an appeal over
13 the phone is a questionable process because you are then
14 depending upon the person on the other end of the phone
15 to accurately capture all the information related to the
16 appeal. That's why the request is to have it made in
17 writing.

18 Q. But isn't the person on the other end of the
19 phone someone that works for the insurer?

20 A. Yeah, but, you know, if you and I have a
21 conversation, the interpretation of what each of us is
22 saying may not always be the same.

23 Q. Wouldn't someone who works for an insurer have
24 a better understanding of what would be required to be
25 submitted for an appeal than a patient?

Page 96

1 A. Well, certainly there's a phone number here.
2 You can call it to find out what information you should
3 submit for an appeal. I think we are talking about two
4 different things. I'm talking about the fact that the
5 insurer wants written documentation that an appeal is
6 being made. If it's done over the phone, the only
7 written documentation is that created by the insurance
8 company itself. And, you know, that's -- it's like
9 pretty much the way the law works, you know, you want
10 something that -- you wouldn't call up somebody and say
11 I'm going to sue you now and this is why. You would
12 submit a document, a complaint in the case of a legal
13 filing, and this is the same thing. The insurance
14 company wants documentation as to what the appeal is
15 about.

16 Q. I will note that almost all legal documents
17 are now submitted online.

18 A. Well, not over the phone. I certainly
19 understand that, but they're not done over the phone.

20 Q. On page 3 of Exhibit 5 of the EOB, it talks
21 about insurance fraud and it has -- it reiterates
22 specifically the number to call if there are concerns
23 about insurance fraud. Do you see that?

24 A. I do.

25 Q. Is there a reason why the number isn't

Page 97

1 specifically reiterated in the section about appeals?

2 MR. DEEGAN: Object to form.

3 THE WITNESS: I don't know. From my notes it
4 isn't, but I don't know why.

5 BY MR. ZIPPERIAN:

6 Q. Do you know who at United HealthCare was
7 tasked with the design of the EOB?

8 A. No.

9 Q. Do you know if that was one person or a group
10 of people?

11 A. I don't know, but at least from my experience,
12 it would be a group of people.

13 Q. There's nothing in the EOB that specifically
14 states that if a member is seeking information about
15 codes specifically, what they should do; is that right?

16 A. I think that, at least it seems to me, to be
17 obvious that the information at the top of the page
18 where it says "If you have questions" is what you should
19 do is -- includes the codes.

20 Q. And it's your belief that the myuhc.com
21 website provides information to members about those
22 codes?

23 A. I don't know because I wasn't able to get into
24 the specific user pages on the website, so I can't
25 answer that.

Page 98

1 Q. If it didn't provide that information, would
2 you consider that to be a problem?
3 A. No, because I think there is more opportunity,
4 here there's a phone number to call, if you were not
5 satisfied with the information on the website, you can
6 call and ask.
7 Q. And I think we can agree that the phone number
8 is not preceded by the statement "have more questions
9 about your claim"; is that right?
10 A. That's correct.
11 Q. And there's nothing in the notes itself, for
12 instance, after the remark code, that says if you have
13 questions about this note or code, please call us at,
14 and it doesn't provide a phone number; right?
15 A. No, there's nothing that specifically. It
16 describes, I think, that the phrase "have more
17 questions" covers the remark codes. Doesn't cover it
18 separately.
19 Q. You write in your experience working on
20 healthcare claims:
21 "It is typical for the member who
22 receives a denial to contact the provider for
23 more information about the reason for the
24 denial."
25 Do you see that?

Page 99

1 A. Yes.
2 Q. When you say "working on healthcare claims,"
3 what do you mean?
4 A. Well, the experience that I described, working
5 on healthcare claims processing systems.
6 Q. What's your basis for saying that it's
7 typical?
8 A. Well, there's -- as I said, it's my experience
9 in which I have worked with health plans and we've
10 talked about denials and the process for denials in a
11 number of instances, but there's also information
12 submitted in the declaration of Savercool in which she
13 identifies the number of times inquiries were made to
14 United on the specific claims that are of interest in
15 the case. She doesn't include inquiries or contacts
16 with providers.
17 Q. And that's what I'm specifically asking about
18 right now. So what's your basis for saying that it's
19 typical for members to contact providers?
20 A. Oh, I see. I was misinterpreting your
21 question. I can't tell you more at this point than that
22 it's my experience. But you can see for yourself when
23 you see the instructions from the Breastfeeding Resource
24 Center, the Breastfeeding Resource Center is in a sense
25 creating a partnership between the patient and

Page 100

1 themselves to get to communicate. So, for example,
2 right on here it says --
3 Q. Just for clarity, you're referring to Miller
4 No. 4?
5 A. Whatever Hoy No. 110 is.
6 Q. That's No. 4.
7 A. No. 6 says:
8 "Oftentimes claims are denied because of
9 incorrect diagnosis or procedure codes. Please
10 call our office and we will help you to refile
11 the claim."
12 That's what people do.
13 Q. Have you ever worked for a provider? And by
14 that I mean in a provider's office.
15 A. In a consulting basis, but not as an employee.
16 Q. Have you ever had any contact with patients
17 who are contacting their provider after receiving a
18 denial from the health insurance company?
19 A. Contact with specific patients?
20 Q. Yes.
21 A. No.
22 Q. Miller No. 4, is it your understanding that
23 this information is given before or after a patient
24 receives a denial, if you have any understanding one way
25 or the other?

Page 101

1 A. I don't. I don't know. But my sense is that
2 it is done before. Content of the exhibit implies that
3 it's done before.
4 Q. I think you said before, and correct me if I'm
5 wrong, that it is not the provider's responsibility to
6 provide information to United HealthCare members about
7 their claims denial process; is that right?
8 A. Well, I was responding to your use of the term
9 responsibility. They are not required to do that, but
10 it is certainly in their interest.
11 Q. So let's take that in two parts. When you say
12 it's not their responsibility, providers have contracts
13 with health plans; right?
14 A. In many instances, yes.
15 Q. And typically, in order to be an in-network
16 provider, you have to have a contract with a health
17 plan?
18 A. Yes.
19 Q. And those contracts, in your experience,
20 outline the rights and responsibilities both of the
21 provider and of the health plan; is that right?
22 A. Yes.
23 Q. Are you aware of any contracts between a
24 provider and United HealthCare that states that it's the
25 provider's responsibility to field questions from

Page 102

1 insureds about remark codes on EOBs?

2 A. No. It certainly doesn't indicate that they

3 are responsible for that, but as I said before, they

4 have a vested interest in doing that.

5 Q. And you are actually right into my next

6 question. So what -- explain to me what the vested

7 interest is.

8 A. Well, the provider wants to be paid and it

9 will be a lot more efficient for the provider to be paid

10 by the insurer as opposed to by the patient, and the

11 providers understand this, whether they, the payer, is a

12 government program like Medicare or an insurer like

13 United, understand that the more they can do to respond

14 to questions raised by the insurer, the more likely it

15 is that they will be paid. I mean, that's their vested

16 interest.

17 Q. Is it fair to say that they're entitled to be

18 paid regardless of whether an insurer is paying or the

19 patient is paying?

20 MR. DEEGAN: Object to form.

21 THE WITNESS: I don't know how to answer that

22 question. Entitled, if you're asking that in the legal

23 sense, I have no answer because I'm not an attorney.

24 If you're asking whether they feel they're entitled to

25 be paid, I imagine they do.

Page 103

1 BY MR. ZIPPERIAN:

2 Q. Obviously, not all patients have insurance;

3 correct?

4 A. Correct.

5 Q. And when they go to a healthcare provider, the

6 healthcare provider expects that they will be paid for

7 the service rendered to that person; is that right?

8 A. Yes.

9 Q. I understand your testimony is that it's

10 certainly easier if an insurer is paying; correct?

11 A. Yes, but I was specifically relating to a

12 situation where there is insurance.

13 You know, typically, if you go to a provider

14 and you don't have insurance, they may ask you to pay in

15 advance, so that's pretty efficient. But if somebody

16 has insurance, it's very much in the provider's interest

17 to work with the patient in order to get paid, because

18 introducing the insurance into the process certainly is

19 more complex than just taking a check.

20 Q. Does an EOB advise members to contact their

21 providers with questions?

22 A. No, not speaking specifically of the EOBs that

23 I've identified, they do not.

24 Q. Are you aware of any healthcare EOBs that

25 direct patients to contact their providers with

Page 104

1 questions about denials?

2 A. No.

3 Q. Why not?

4 MR. DEEGAN: I'm going to object to form.

5 THE WITNESS: I can't tell you why they

6 don't. You'd have to ask somebody at United.

7 BY MR. ZIPPERIAN:

8 Q. Do you know what percentage of time members

9 contact their providers for more information after

10 they've received a denial?

11 A. I've not seen any statistics on that.

12 Q. Does a health plan have a vested interest in

13 denying claims?

14 MR. DEEGAN: Object to form.

15 THE WITNESS: Well, I think that -- that

16 there's a common feeling that that's the case, but in

17 my experience, it isn't, because a health plan

18 obviously has financial interests in terms of payment

19 of claims, but they also have even greater financial

20 interest in the preservation of customer relationships.

21 So I think there are overriding situations that -- and

22 I certainly have a good experience on this point --

23 overriding consideration where the health plan

24 recognizes that denial of claims have to be done

25 accurately and appropriately in order for them to

Page 105

1 maintain their support.

2 I can tell you that I have worked for large

3 employers, very large employers, in their negotiations

4 of contracts with health insurance companies and one of

5 their main issues is whether or not they're going to get

6 complaints from their employees about things like

7 denials.

8 So, yeah, they have a financial interest in

9 denials, but their interests are much broader than that

10 and I don't think they have a vested interest in denying

11 claims.

12 BY MR. ZIPPERIAN:

13 Q. Are you familiar with the term medical loss

14 ratio?

15 A. Yes.

16 Q. What does that term mean?

17 A. It's a ratio where the numerator is the

18 amount of dollars expended in the payment of claims and

19 the denominator is the total premiums that are

20 collected.

21 Q. And how do insurers use that ratio --

22 MR. DEEGAN: Object to form.

23 BY MR. ZIPPERIAN:

24 Q. -- in their -- strike that.

25 If a provider has a question about a remark

Page 106

1 code, how do they get more information about that remark
 2 code from United HealthCare?
 3 MR. DEEGAN: Object to form.
 4 THE WITNESS: They also call and ask.
 5 BY MR. ZIPPERIAN:
 6 Q. And is there a specific department that
 7 answers questions from providers about remark codes?
 8 MR. DEEGAN: Same objection.
 9 THE WITNESS: I haven't asked that question.
 10 That would be outside the scope of what I was doing, so
 11 I don't know.
 12 MR. ZIPPERIAN: I think it might be a good
 13 time to take a lunch break if everyone else feels the
 14 same way?
 15 MR. DEEGAN: That's fine.
 16 THE VIDEOGRAPHER: Off the record at
 17 12:10 p.m.
 18 (Lunch recess taken.)
 19 THE VIDEOGRAPHER: We are on the record at
 20 12:53 p.m.
 21 BY MR. ZIPPERIAN:
 22 Q. Welcome back, Dr. Miller.
 23 A. Thank you.
 24 Q. I'm going to direct you to page 5 again of
 25 your expert report. You state it is common -- this is

Page 107

1 in the middle of the page:
 2 "It is common for members to reach out
 3 directly to the health plan seeking more
 4 information."
 5 Do you see that? It's the last sentence in
 6 the third paragraph.
 7 A. Oh. Yes.
 8 Q. What's your basis for that statement?
 9 A. Well, a number of things. Once again, my
 10 experience in working with health plans. Also, I
 11 mentioned previously the declaration by Savercool in
 12 which she identifies the portion of times that contacts
 13 were made for specific remark codes, and also there is
 14 direction on the EOB, obviously, that we've talked about
 15 before that directs the member to reach out, and
 16 previously I talked about the question on the top of the
 17 page about having more questions about your claim, but I
 18 didn't mean to exclude by saying that. There's a lot
 19 more information in the EOB about being able to ask
 20 questions.
 21 Q. What are you referring to specifically?
 22 A. Under notes we previously talked about.
 23 MR. DEEGAN: Which exhibit are you referring
 24 to?
 25 THE WITNESS: I am looking at the first of

Page 108

1 the exhibits on -- this might be No. 3, Jance Hoy.
 2 BY MR. ZIPPERIAN:
 3 Q. I think that's Miller 5. Is it Bates-numbered
 4 in the upper right-hand corner 887 on the first page?
 5 877?
 6 A. 877.
 7 Q. 877. Yeah. That's Miller 5. Thank you.
 8 A. In that EOB, after the information about the
 9 claim payment and the note, the KM note, the next
 10 paragraph identifies the appeal process and then it also
 11 indicates that if you're in a plan governed by ERISA,
 12 you have a right to file a civil action, but then it
 13 also says:
 14 "You or your authorized representative,
 15 such as family member or physician, may appeal
 16 the decision by submitting comments, documents
 17 or other relevant information to the appeal
 18 address referenced above. You may request
 19 copies free of charge of information relevant
 20 to your claim by contacting us."
 21 And then, you know, that's for the insurance
 22 company. It also provides information about consumer
 23 assistance, ombudsmen services. And then there's
 24 further information about appeals and meeting needs
 25 online.

Page 109

1 So there's a good deal of information that
 2 directs the member to contact the health plan right in
 3 the EOB, but the fact that they actually do that is on
 4 Ms. Savercool.
 5 Q. Who's Savercool?
 6 A. An employee of United HealthCare. I don't
 7 remember her specific title.
 8 Q. Have you had any communications with her other
 9 than reading her declaration?
 10 A. No.
 11 Q. The paragraphs that you note on Miller No. 5
 12 and, for instance, "You or your authorized
 13 representative may appeal the decision by submitting
 14 comments, documents or other relevant information to the
 15 appeal address referenced above" -- do you see that?
 16 A. I do.
 17 Q. Does that indicate to you that they are to
 18 write to that address providing information that they
 19 deem to be relevant?
 20 A. Yes.
 21 Q. And if they want more information relevant to
 22 their claim or copies of information, they should write
 23 to the P.O. box address?
 24 A. Not necessarily. It just says "by contacting
 25 us at the above address," and the contact information

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| <p style="text-align: right;">Page 110</p> <p>1 includes a phone number.</p> <p>2 Q. Do you think that above address is referring</p> <p>3 to the address at the top of the page and not the</p> <p>4 address in the appeals section?</p> <p>5 A. I do.</p> <p>6 Q. What's your reason for believing that?</p> <p>7 A. Well, the sentence that we're talking about</p> <p>8 about requesting copies of information relevant to the</p> <p>9 claim does not specifically reference appeal. It's a</p> <p>10 more general sentence and, therefore, I think it applies</p> <p>11 to the service center.</p> <p>12 Q. And is it fair to say there are two addresses</p> <p>13 above that sentence in this document?</p> <p>14 A. Yes.</p> <p>15 Q. Do you know what percentage of members who</p> <p>16 receive denials from UHC contact UHC about denials?</p> <p>17 A. No. The Savercool deposition -- declaration,</p> <p>18 rather -- identifies the data in a different way. It</p> <p>19 wouldn't allow you to do that.</p> <p>20 Q. Do you know if members reach out through the</p> <p>21 website, through telephone calls or by mail? Do you</p> <p>22 know the percentage of how that breaks down?</p> <p>23 A. No.</p> <p>24 Q. Have you ever advised a health plan in their</p> <p>25 design of remark codes?</p> | <p style="text-align: right;">Page 112</p> <p>1 Combination?</p> <p>2 A. The CORE Code Combination is also -- is a</p> <p>3 program of CAHQ, which is a nonprofit organization</p> <p>4 devoted to healthcare issues and it is specifically</p> <p>5 focused, the CORE component of it, is specifically</p> <p>6 focused on what they refer to as the intraoperability of</p> <p>7 electronic data systems between insurers and payers, in</p> <p>8 the broader sense, including Medicare and Medicaid and</p> <p>9 providers and consumers as well. But their concern</p> <p>10 is -- they do publish codes, but their concern is more</p> <p>11 focused on the communication between the parties and the</p> <p>12 healthcare system. It's healthcare specific.</p> <p>13 Q. What do CARC and RARC refer to?</p> <p>14 A. These are different -- CARC, claims adjustment</p> <p>15 reason codes, and RARC I guess would be the remittance</p> <p>16 of adjustment mixing codes and they are the codes that</p> <p>17 are used to describe actions on claims payment.</p> <p>18 Q. What is the Washington Publishing Company?</p> <p>19 A. Pretty much what it sounds like. It's an</p> <p>20 independent publishing company. They have taken on the</p> <p>21 responsibility of publishing coding information in a</p> <p>22 broad sense from within -- I don't know what they do</p> <p>23 with other industries, but within the healthcare</p> <p>24 industry, so they are a source to turn to if you want a</p> <p>25 compendium of codes.</p> |
| <p style="text-align: right;">Page 111</p> <p>1 A. I think I answered this question earlier and</p> <p>2 indicated that I've reviewed and discussed the remark</p> <p>3 codes but I have not specifically participated in the</p> <p>4 design of the remark codes.</p> <p>5 Q. What is your experience with the X12</p> <p>6 organization?</p> <p>7 A. My experience is that it's a resource that</p> <p>8 I've used in other instances as well to identify remark</p> <p>9 codes.</p> <p>10 Q. What is the X12 organization?</p> <p>11 A. X12 is kind of a branch, I guess, which used</p> <p>12 to be the National Bureau of Standards. I guess it's</p> <p>13 now called the National Standards Institute. It's a</p> <p>14 nonprofit organization that undertakes industry wide</p> <p>15 investigations and analyses to support the development</p> <p>16 and use of standardized coding, information, among other</p> <p>17 standardized information in a number of different</p> <p>18 industries.</p> <p>19 Q. Including the healthcare industry?</p> <p>20 A. Yes.</p> <p>21 Q. And do you know if one of their considerations</p> <p>22 in creating the codes is that they be easily</p> <p>23 understandable by a layperson?</p> <p>24 A. I don't know that, no.</p> <p>25 Q. What's your experience with the CORE Code</p> | <p style="text-align: right;">Page 113</p> <p>1 Q. Do you consider the RARC language published by</p> <p>2 the Washington Publishing Company to be the industry</p> <p>3 standard for coding language?</p> <p>4 A. It is intended to be the industry standard and</p> <p>5 most participants in the industry either use it directly</p> <p>6 or make sure that the descriptions that are included</p> <p>7 there are representative of their own descriptions. So,</p> <p>8 yeah. It's a longer answer than necessary. Yes, I do</p> <p>9 think it's the industry standard.</p> <p>10 Q. Is there a reason why a health insurer would</p> <p>11 use language that they find to be similar to the RARC</p> <p>12 codes but not the exact language?</p> <p>13 A. Yes.</p> <p>14 Q. What reason would that be?</p> <p>15 A. I think that it's an effort on the part of</p> <p>16 insurers to do two things. One is sort of make it their</p> <p>17 own. You know, there's -- not all insurance do. There</p> <p>18 are some insurers that usually adopt the language as it</p> <p>19 is in the X12 coding descriptions, but insurers like</p> <p>20 United make an effort, I believe from my review of it,</p> <p>21 make an effort to, as I've said earlier today, turn the</p> <p>22 more technical language in the X12 information into</p> <p>23 language that is more applicable to a layperson.</p> <p>24 Q. Is it your belief then that the language that</p> <p>25 United HealthCare uses is more easily understandable by</p> |

Page 114

1 a layperson than the RARC language?
 2 A. What I'm saying is I think United believes
 3 that to be the case. I think whether or not whether it
 4 is or isn't more understandable would depend upon each
 5 person's sense of what understandability is.
 6 Q. And what do you believe to be the case? Do
 7 you believe that it is more easily understandable?
 8 A. I do. I do.
 9 Q. I'm going to ask you to take a look at the
 10 chart that starts on page 6. And you list the four
 11 codes that are at issue and then you have the text of
 12 the UGH code and then the UGH mapped CMS/X12 codes and
 13 the text for those codes. Do you see that?
 14 A. I do.
 15 Q. Can we take a look at page 7 at the I5 code
 16 and compare the language on the far left with the Hoy
 17 EOB, which is Miller 6.
 18 A. Yes.
 19 Q. The second page of Miller 6 has an I5 code
 20 listed there. Do you see that?
 21 A. Em-hmm.
 22 Q. The language in your report says:
 23 "This service is not reimbursable in
 24 this place of service."
 25 Do you see that?

Page 115

1 A. Yeah.
 2 Q. And the language on the EOB says:
 3 "This service code is not separately
 4 reimbursable in this setting."
 5 Do you see that?
 6 A. Yeah.
 7 Q. So is that just a mistake that you made in the
 8 chart? I'm only asking because those two things are
 9 different.
 10 A. Yeah. No. I understand. I understand. No.
 11 The reason I chose -- hmm -- it may be a mistake. I
 12 didn't -- I may not have looked at the same source. I
 13 can't give you a reason as to why it's not exactly the
 14 same.
 15 Q. All right. Do you find the difference in the
 16 language to be significant?
 17 A. No. But there's a difference. The difference
 18 is the use of the word separately. Setting versus place
 19 of service to me would mean the same thing. So there's
 20 definitely a difference. I certainly wasn't intending
 21 that to be different.
 22 Q. But the difference is not material to your
 23 opinion; is that correct?
 24 A. Correct.
 25 Q. Do you know where the language "this service

Page 116

1 is not reimbursable in this place of service" came from?
 2 A. Might have been my head. I don't remember.
 3 Q. Okay. And in any event, there does seem to be
 4 a difference between the language used by United
 5 HealthCare and the language used by CMS and X12. And
 6 the language used by United HealthCare is "This service
 7 code is not separately reimbursable in this setting" and
 8 the language used by CMS is "This procedure code/type of
 9 bill is inconsistent with the place of service"?
 10 A. Yes.
 11 Q. Do you think that those differences are
 12 material?
 13 A. No.
 14 Q. The language that you use in your chart does
 15 not refer to a code. Do you see that in the I5
 16 language?
 17 A. What do you mean?
 18 Q. So this language here, there is no reference
 19 there to a code. Do you see that?
 20 A. Well, it refers to the I5 code.
 21 Q. In the language itself?
 22 A. Oh. No. The language is a rephrasing of the
 23 actual language. And like I said, I don't know the
 24 reason for that. Probably an error on my part.
 25 Q. Do you think the inclusion of the word "code"

Page 117

1 is important in that remark code? Let me say in the
 2 language used in that remark code?
 3 A. No. Now I see. You're saying the word code.
 4 Q. Right.
 5 A. No.
 6 Q. You don't think that the use of the word code
 7 adds clarity to a member in terms of what the problem
 8 was?
 9 A. Maybe. I think that's an individual
 10 determination. I don't think for most people it would
 11 add clarity or having it there or not I don't think
 12 would make much of a difference.
 13 Q. Is it a member's responsibility to bring EOBs
 14 and denials to the attention of their provider?
 15 MR. DEEGAN: Object to form.
 16 THE WITNESS: Is it their responsibility? If
 17 they want something in the -- relating to the claim to
 18 be addressed, I wouldn't call it a responsibility, but
 19 it would be an obvious thing to do.
 20 BY MR. ZIPPERIAN:
 21 Q. What would make it obvious?
 22 A. Well, when you see, regardless of the wording,
 23 that the service is not separately reimbursable in this
 24 setting, it would lead me to ask the question what makes
 25 it so, you know, what is the setting, and you can ask

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| <p style="text-align: right;">Page 118</p> <p>1 your provider or you can ask, in this case, United 2 HealthCare, and United HealthCare is probably going to 3 give you an answer that would lead you to ask your 4 provider anyway.</p> <p>5 Q. So it's your understanding that United 6 HealthCare would, if a member called with questions 7 about a denial, that the member would be directed by 8 United HealthCare to contact their provider?</p> <p>9 A. That was not what I was saying. It's possible 10 that that would happen, but the response that United 11 HealthCare provided, whether or not they said 12 specifically you should contact your provider, would be 13 likely to lead the member to want to contact the 14 provider.</p> <p>15 Q. And why would it lead them to want to contact 16 their provider?</p> <p>17 A. Well, I think that the -- suppose the 18 response -- you'd have to think about what the responses 19 could be. But if the response is that the setting 20 refers to the place of service and this particular item 21 of service, we don't pay for that according to your 22 benefit plan when it's provided in that specific place 23 of service and I would -- you know, you don't have to 24 tell somebody that they should contact their provider, 25 but to me that's what I would do. I think most people</p> | <p style="text-align: right;">Page 120</p> <p>1 specifically relates -- specific intent relates to the 2 submission of information relating to an appeal, but I 3 think it implies that your provider may have information 4 for you.</p> <p>5 Q. I'd like you to take a look at, on page 6, the 6 B5 code. The B5 code language for United HealthCare 7 says: 8 "Benefits for this service are denied. 9 We sent a letter to the member asking for 10 additional information. We have not received a 11 response." 12 Do you see that? 13 A. I do. 14 Q. And the information or the text from the CRAC 15 codes says: 16 "Information requested from the 17 patient/insured/responsible party was not 18 provided or was insufficient, incomplete." 19 Do you see that? 20 A. I do. 21 Q. So the CARC language indicates that 22 information had already been requested from the patient 23 and the language from United HealthCare says that they 24 sent that information. Does not indicate that they have 25 received a response. Do you see that?</p> |
| <p style="text-align: right;">Page 119</p> <p>1 would do that. And again, it may not be so specific, 2 but even in the Breastfeeding Resource Center 3 information where it talks about claims being denied, 4 the instruction is to call our office.</p> <p>5 There aren't that many people involved in a 6 claim. There's the member, the provider and the 7 insurer. And if you have -- if you have questions as 8 the member, you only have your choice of two people to 9 call, and you may call -- it would seem likely if you 10 had questions about information that you received, you 11 would call the provider. Providers get those calls all 12 the time.</p> <p>13 Q. I think we talked earlier about your 14 experience with providers and your basis for saying that 15 providers get those calls all the time. We don't have 16 to go through that again.</p> <p>17 A. Okay. And I would point out too that later on 18 in the -- under the notes, it specifically mentioned 19 that you or an authorized representative, such as a 20 physician, may appeal by submitting comments and 21 documents. And I think that too helps the insured, 22 think about contacting their provider.</p> <p>23 Q. You think that's the intent of that sentence, 24 is to direct a member to their provider?</p> <p>25 A. I think that's one of the intents. The intent</p> | <p style="text-align: right;">Page 121</p> <p>1 A. Em-hmm. I do. 2 Q. Is that a significant difference in your mind? 3 A. I think it says the same thing. 4 Q. So you don't think that it's significant? 5 A. No. 6 Q. And I think that the way I read it, the 7 difference is that the CARC language indicates that 8 information was requested and that it was either that 9 the response was either insufficient or incomplete and 10 there's no mention of a response, an incomplete response 11 or insufficient response in the United HealthCare 12 language. 13 A. Well, the language in the CRC is that the 14 information was either not provided or was insufficient 15 or incomplete. I don't think that it's significant, 16 because the United HealthCare language says we sent a 17 letter to the member asking for additional information, 18 we haven't received a response. 19 If in fact they had received a response and 20 the information was insufficient or incomplete, it 21 doesn't really matter. You know, I think that the point 22 here is that this particular code is being used by 23 United when they don't receive a response. It is mapped 24 to the CARC, because the CARC code description is the 25 closest to the United code, but it isn't required that</p> |

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| <p style="text-align: right;">Page 122</p> <p>1 it match exactly.</p> <p>2 Q. Do you know if there's a standard letter that</p> <p>3 United HealthCare sends out requesting additional</p> <p>4 information from members?</p> <p>5 A. I'm trying to remember whether or not I saw it</p> <p>6 as part of the documentation I reviewed, because I</p> <p>7 vaguely remember, but I don't remember it clearly</p> <p>8 enough. I believe there is a standard letter, yes.</p> <p>9 Q. I'm assuming, based on what you just said,</p> <p>10 that you don't know what that letter says?</p> <p>11 A. I would say I don't remember what that letter</p> <p>12 says.</p> <p>13 Q. Taking a look at the second chart, how are the</p> <p>14 RARC codes used in the second chart different from those</p> <p>15 used in the first chart?</p> <p>16 A. The CARC codes more typically are sent to the</p> <p>17 member. The RARC codes were typically sent to the</p> <p>18 provider.</p> <p>19 Q. Are RARC codes standalone codes?</p> <p>20 A. Well, they can be. They're always part of a</p> <p>21 context.</p> <p>22 Q. Is it your understanding you can have an RARC</p> <p>23 code independent of a CARC code?</p> <p>24 A. I'm trying to remember instances where that's</p> <p>25 been the case. I believe it's possible, but I --</p> | <p style="text-align: right;">Page 124</p> <p>1 functioned as expected and that plaintiffs</p> <p>2 understood the core reasons of their denials."</p> <p>3 Starting with the first part of that, that</p> <p>4 they functioned as expected, what you do you mean by</p> <p>5 that?</p> <p>6 A. That they effectively communicated the point</p> <p>7 that they were intending to communicate.</p> <p>8 Q. Which was?</p> <p>9 A. The reason for the denial.</p> <p>10 Q. Did they do anything else? Did they perform</p> <p>11 any other functions?</p> <p>12 A. Well, the only other function that they could</p> <p>13 perform was to provide a basis for further discussion if</p> <p>14 the insured was to call United or their provider.</p> <p>15 Q. Can a remark code both effectively communicate</p> <p>16 the reason for denial and initiate a dialogue about the</p> <p>17 reason for the denial?</p> <p>18 A. Sure.</p> <p>19 Q. Explain that to me.</p> <p>20 A. Well, the code, the description, identifies</p> <p>21 the reason for the denial and that many people looking</p> <p>22 at the information that's included in the description I</p> <p>23 would expect would want to find out more so that they</p> <p>24 don't necessarily direct the insured to find out more,</p> <p>25 but it's obvious that if they do want to find out more,</p> |
| <p style="text-align: right;">Page 123</p> <p>1 usually not.</p> <p>2 Q. How are the two usually related?</p> <p>3 A. What do you mean by related?</p> <p>4 Q. Or how are the two usually used in conjunction</p> <p>5 with one another?</p> <p>6 A. The CARC is used in the claims adjustment --</p> <p>7 claims adjudication process and, therefore, its primary</p> <p>8 use is for the member.</p> <p>9 The RARC is used in the submission of</p> <p>10 remittance advices to providers most of the time.</p> <p>11 Remittance advices can also go to members, but most of</p> <p>12 the time they go to providers. So that is the context</p> <p>13 in which they're used. Yeah.</p> <p>14 Q. Are RARC codes sent to members?</p> <p>15 A. Well, they may be, but I don't know that the</p> <p>16 member would know that that's an RARC code. As you can</p> <p>17 see, frequently they're identical. So I don't know how</p> <p>18 you distinguish.</p> <p>19 Q. On page 8 after the second chart in the</p> <p>20 written paragraph, you say that you:</p> <p>21 "Reviewed deposition testimony and</p> <p>22 associated exhibits from plaintiffs regarding</p> <p>23 their individual experiences with UHG's remark</p> <p>24 code descriptions. That testimony confirms</p> <p>25 that UHG's industry-standard remark codes</p> | <p style="text-align: right;">Page 125</p> <p>1 how they can do that.</p> <p>2 Q. And it's your belief that the way that they</p> <p>3 would do that is go to myuhc.com or call the telephone</p> <p>4 number on the EOB?</p> <p>5 A. Or call their provider. Yes.</p> <p>6 Q. And then the second part of that sentence is</p> <p>7 that that testimony confirms that plaintiffs understood</p> <p>8 the core reasons for their deductibles. Do you see</p> <p>9 that?</p> <p>10 A. I do.</p> <p>11 Q. Is it your belief that the plaintiffs in this</p> <p>12 case understood the core reasons for their denials after</p> <p>13 seeing their remark codes?</p> <p>14 A. Well, I don't know when they understood it,</p> <p>15 but in terms of the discussion in the depositions,</p> <p>16 that's what is clear. So I don't know if they</p> <p>17 understood them immediately or they understood them at a</p> <p>18 later point in time, but their comments in their</p> <p>19 deposition imply that they understood them.</p> <p>20 Q. So just looking at that sentence, the second</p> <p>21 part of that sentence that plaintiffs understood the</p> <p>22 core reasons for their denial, is it your testimony that</p> <p>23 that's not related to how the remark codes functioned?</p> <p>24 A. No. No. I'm not saying that at all. You</p> <p>25 asked me a question in such a way so as -- for me to</p> |

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| <p style="text-align: right;">Page 126</p> <p>1 determine whether they -- their understanding of the 2 reasons for their denials was immediate upon reading the 3 code or was later. I don't know what was going on in 4 their minds.</p> <p>5 Q. And I'm not trying to put any words in your 6 mouth. I'm just trying to be clear about what you're 7 saying there and I want to understood.</p> <p>8 Are you saying that at some point the 9 plaintiffs understood the core reasons for their denials 10 but not necessarily as a result of reading the remark 11 codes?</p> <p>12 A. No, not really. What I'm saying is that in 13 their depositions it was clear that they understood it, 14 but I don't -- how -- you know, what their thought 15 process was is not something I can tell you about.</p> <p>16 Q. Okay. And what I'm trying to understand is 17 are you saying in your report that the reason they 18 understood their denial was because of the remark codes?</p> <p>19 A. Well, it was certainly the remark codes played 20 a role in that, but all I'm saying in that sentence is 21 that the plaintiffs understood the core reasons for 22 their denials. I'm not identifying how or when they 23 understood it. I'm just saying that when they were 24 deposed, it was clear that they understood it.</p> <p>25 Q. Okay. And you cite a number of documents for</p> | <p style="text-align: right;">Page 128</p> <p>1 that they were classified as parenting classes?</p> <p>2 A. That's what I'm understanding from what she is 3 saying.</p> <p>4 Q. Where in the EOB would it tell her that they 5 were classified as parenting classes?</p> <p>6 A. Well, I don't know. I think that she may have 7 conducted additional investigation to find that out. 8 Let's see if we can find her EOB. This is an I3 -- or 9 it's a 13, rather -- a 13 code. And it says: 10 "Your plan doesn't cover this nonmedical 11 service or personal item." 12 And as to -- 13 Q. Just for clarity sake, you are looking at 14 Miller No. 8?</p> <p>15 A. Yes. Page 3. And she provides additional 16 information by saying that the nonmedical service that 17 was identified, she's identifying as parenting classes, 18 which implies to me that she may have had a discussion 19 with somebody at United to find that out, but it seems 20 clear that she knows why it was that it was denied.</p> <p>21 Q. And when you say it seems clear, you're basing 22 that on the first sentence of the letter?</p> <p>23 A. Yes.</p> <p>24 Q. Is there anywhere in the letter that 25 Ms. Barber indicates that the remark code on her EOB</p> |
| <p style="text-align: right;">Page 127</p> <p>1 that proposition. Let's see, where are we at? Are we 2 at Miller letter 9?</p> <p>3 THE REPORTER: Ten.</p> <p>4 MR. ZIPPERIAN: Let's start with that one. 5 (Exhibit 10 was marked for identification.) 6 BY MR. ZIPPERIAN: 7 Q. Miller 10 is a letter from Felicity Barber to 8 whom it may concern, Bates No. PL, underscore, FB000015. 9 I'll ask you to take a look at at Miller 10 for a 10 second.</p> <p>11 A. Okay.</p> <p>12 Q. Have you seen Miller 10 before?</p> <p>13 A. I have.</p> <p>14 Q. It's a letter that acknowledges that 15 Ms. Barber's claims were denied and it is appealing the 16 basis of that denial, that the breastfeeding support 17 services support should be covered; right?</p> <p>18 A. Correct.</p> <p>19 Q. Where does it indicate in this letter that 20 Ms. Barber knew the reason for the denial of her claim?</p> <p>21 A. Well, she starts the letter by saying that she 22 filed two claims for breastfeeding support and both were 23 classified as parenting classes and then she's appealing 24 the decision on the basis of that classification.</p> <p>25 Q. Does it say that she's appealing on the basis</p> | <p style="text-align: right;">Page 129</p> <p>1 offered her sufficient understanding for the basis of 2 her denial?</p> <p>3 A. No. It looks to my as though she must be a 4 patient of a Breastfeeding Resource Center, because they 5 provide a sample letter to their patients and a lot of 6 the language from the letter, the sample letter, is what 7 Felicity Barber used and that doesn't identify anything 8 about remark codes.</p> <p>9 Q. Does United HealthCare provide any kind of 10 similar letter for their members to file appeals?</p> <p>11 A. No.</p> <p>12 MR. ZIPPERIAN: All right. Let's mark these 13 as Miller 11 and Miller 12. 14 (Exhibits 11 and 12 were marked 15 for identification.) 16 BY MR. ZIPPERIAN: 17 Q. Miller 11 and Miller 12 have been previously 18 marked as Endicott 58 and Endicott 59.</p> <p>19 A. Em-hmm. Yes.</p> <p>20 Q. Can you tell me what about Endicott 58 and 21 Endicott 59, Miller 11 and 12, indicates to you that 22 Mrs. Endicott, Ms. Endicott, understood the core reasons 23 for the denial of her claims?</p> <p>24 A. Well, the -- again, if we can find her EOB. I 25 don't remember which exhibit the Endicott EOB is.</p> |

Page 130

1 Q. I don't think we've gotten it yet. Oh. It is
2 Exhibit 7.

3 A. I'm not sure that all of this matches up. It
4 does. The EOB is the -- is the determination that was
5 sent to Christine Endicott on December 15th using the B5
6 code, payment for the services --

7 "Payment for services denied. We asked
8 the member for more information and we didn't
9 receive it on time."

10 And the member, I think -- if this is 11 and
11 12, I think it's in No. 12 -- received prior to that on
12 November 26th, 2015 a copy of a letter sent to her
13 provider indicating what information was missing. I
14 guess I can't say that she understood it, but I think if
15 she read it, it's reasonable to expect that she
16 understood it.

17 She knew that additional information was being
18 requested. She was informed of that. And the letter
19 informing her gives the provider 45 days to respond.
20 And so seems to me to be clear that she knew what the
21 reason was.

22 MR. DEEGAN: I just have a question about
23 this copy of 12. Do you have a copy that is legible?
24 It looks like there's a note on the front.

25 MR. ZIPPERIAN: I don't. That's the only copy I

Page 131

1 have. I believe that the note says "I called to UHC
2 about this. I was told I was supposed to send this to
3 Lori."

4 Q. And what I'm specifically asking about,
5 because you cite these letters for the proposition that
6 the plaintiffs understood the core reason for their
7 denial, so I'm wondering what in Miller 11 and Miller 12
8 leads you to believe that Ms. Endicott understood the
9 reason for her denial?

10 A. Well, she knew that the reason for her denial
11 was information that was requested was not provided.

12 Q. Where in these letters --

13 A. In the letters it doesn't say that, but it
14 says that in her EOB.

15 Q. Okay.

16 A. It does say that there's missing information.
17 It says in both 11 and 12 -- the letter is addressed to
18 the provider and the letter itself says that:

19 "We have requested more information from
20 you but have not yet received it."

21 And a copy of this was sent to Christine
22 Endicott.

23 "So before we can process the claim, we
24 need the following."

25 Q. I'm going to direct you to Miller 12, to the

Page 132

1 first page. It says "Dear Christine Endicott." Do you
2 see that?

3 A. I do.

4 Q. What does the second to last sentence in that
5 paragraph say?

6 A. "You did not" -- second to last?

7 Q. Yes.

8 A. "The letter on the reverse side was sent to
9 the doctor, facility or the healthcare professional."

10 Q. I think that's the third to the last.

11 A. Oh. Okay.

12 "You do not need to respond or take any
13 action at this time. Please keep a copy of
14 this letter for your records."

15 Q. Does that indicate to you that Ms. Endicott
16 should have known that she was required to provide
17 additional information?

18 A. Well, you know, I think that she was not
19 required to provide the additional information. Her
20 provider was required to provide the additional
21 information. And the letter that is referenced in that
22 paragraph says:

23 "We requested information from you and
24 haven't received it," talking about the
25 provider.

Page 133

1 So I don't know what the issue is to whether
2 or not she would see this as an effective communication.
3 Seems pretty effective to me.

4 Q. You think Ms. Endicott upon receipt of this
5 letter should have known that she needed to get
6 additional information from her provider or that her
7 provider needed to submit additional information?

8 A. No, she didn't need to get the additional
9 information. She should have known that her provider
10 needed to provide the additional information. And it
11 clearly says in the letter to the provider:

12 "Your claim is on hold until we receive
13 this information from you."

14 So that this tells me that Christine Endicott
15 knew what it was, the additional information -- she knew
16 that there was more information required. She knew what
17 the additional information was, and she knew it was the
18 provider's responsibility to provide that information.

19 Q. How did she know that?

20 A. It's addressed to the provider.

21 Q. Okay. The first page of that letter again
22 says:

23 "You do not need to respond or take any
24 action at this time."

25 A. Yeah. That's because the provider does.

Page 134

1 Q. And what's the result if the provider fails to
2 take action?
3 A. Well, in this letter it doesn't indicate that.
4 And in Exhibit 11 there's an indication of a limit of 45
5 days, that if they, United, doesn't receive the
6 information, they'll have to deny the claim.
7 Q. And that's a letter addressed to the provider?
8 A. Yes.
9 Q. Who has to pay if the claim is denied, the
10 provider or the member?
11 A. That's up to the provider and the member.
12 MR. DEEGAN: Object to form.
13 BY MR. ZIPPERIAN:
14 Q. Are you aware that Ms. Endicott testified
15 about these letters in her deposition?
16 A. I remember that she did, but I don't remember
17 the specifics.
18 MR. ZIPPERIAN: Let's go ahead and mark this
19 as Miller 13.
20 (Exhibit 13 was marked for identification.)
21 BY MR. ZIPPERIAN:
22 Q. Miller 13 is deposition excerpts of the
23 deposition of Ms. Christina Endicott. I'm going to
24 direct you first to page 37, lines 14 to 25.
25 Ms. Endicott is testifying about Endicott 59, which is

Page 135

1 Miller 12. And there she testifies that, in lines 24
2 and 25:
3 "Yes, my address is on the part of the
4 letter that says I do not need to respond or
5 take any action."
6 Do you see that?
7 A. Yes.
8 Q. And then I'm going to ask you to take a look
9 at page 36, lines 11 to 37, page 37, line 4. That talks
10 about Exhibit 58 to Ms. Endicott's deposition, which is
11 Miller 11. This is, I believe, the second letter just
12 based on the charge. I believe the first letter was
13 2/15 and she talks about letters that were addressed to
14 Lori Atkins, who is her provider; correct?
15 A. Correct.
16 Q. Finally, if we could take a look at pages 40
17 through 42. Specifically, on page 41, line 10, it says:
18 "Did you receive requests for
19 information from United prior to this document?
20 Exhibit 60?"
21 "Requests for information specifically
22 from me, no."
23 "Was there information requested about
24 your claim?"
25 "Yes."

Page 136

1 "And had you provided that information?"
2 "It was requested from Lori Atkins."
3 Do you see that?
4 A. No. Where are you?
5 Q. It's page 41, line 10 through 18.
6 A. I see it, yes.
7 Q. Does this testimony indicate to you that
8 Ms. Endicott understood the core reasons for the denial
9 of the claim?
10 A. Yeah.
11 Q. Because information was requested from her
12 provider?
13 A. Yeah. The reasons for the denial was
14 information was requested and it wasn't provided.
15 Q. Okay. I'll direct you to page 39, lines 23 to
16 25. Question is:
17 "Did you see that it had a reason
18 given?"
19 And her response is:
20 "It's -- yes, but it's a lot of
21 insurance jargon."
22 Do you think that indicates that she
23 understood the reason for her denial?
24 A. Well, I realize that she said that it's a lot
25 of insurance jargon, but it sure doesn't read like it.

Page 137

1 I mean, it says:
2 "It's a B5 code. Payment for services
3 denied. We asked for more information and
4 didn't receive it on time."
5 That doesn't sound like insurance jargon to
6 me.
7 Q. But that was how she interpreted it; correct?
8 MR. DEEGAN: Object to form.
9 THE WITNESS: Well --
10 BY MR. ZIPPERIAN:
11 Q. That's what she said?
12 A. Well, that's what she's saying, yes.
13 Q. I'm going to direct you to page 30, line 23.
14 A. Page?
15 Q. 30, line 23. Actually, starting at line 9.
16 Sorry.
17 A. I'm sorry. What?
18 Q. Page 30, line 9.
19 MR. DEEGAN: Page 30, line 9?
20 MR. ZIPPERIAN: Yes.
21 Q. Question is:
22 "Is it your understanding that you have
23 the responsibility to submit an accurate claim
24 to United for reimbursement?"
25 Response is:

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| <p style="text-align: right;">Page 138</p> <p>1 "The diagnoses on the form were 2 accurate." 3 "How do you know they were accurate?" 4 "Because I was experiencing them 5 myself." 6 "And did you choose them? Did you 7 choose the diagnosis codes?" 8 "No. There's text after the codes that 9 says what the codes mean." 10 "I'm just asking you if you chose them. 11 The answer is no?" 12 "I didn't. Lori did the diagnosis." 13 "Sure. And do you understand what an 14 ICD-9 code is?" 15 "Nope." 16 "Do you understand what an ICD-10 code 17 is?" 18 "No." 19 "Do you know when ICD-10 codes went into 20 effect?" 21 "No." 22 "Did you ever discuss ICD-9 codes -- did 23 you ever discuss when ICD-10 codes went into 24 effect with Ms. Atkins?" 25 "No."</p> | <p style="text-align: right;">Page 140</p> <p>1 information. I can't tell you whether she understood 2 that or not, but that's the provider that provides the 3 information. 4 Q. And let's look at page 32, line 22 to page 33, 5 line 12: 6 "And tell me about the first 7 conversation you had with Ms. Atkins about the 8 letters that you had received." 9 "So I told her that services were not 10 going to be covered. And I had called United 11 to see why and at that time I was told they had 12 a problem with the codes. So I contacted Lori 13 and I said that there were these letters that 14 were addressed to her that I had received 15 saying that I didn't have to do any -- I didn't 16 have to do anything with the letters and that's 17 when I found out she had actually never 18 received the letters. So I circled back and 19 called United again and was told at that point 20 I was actually responsible for sending those 21 letters to Lori to get the information that the 22 letter stated was missing." 23 Do you see that? 24 A. I do see. 25 Q. Do you think that that's accurate, that it was</p> |
| <p style="text-align: right;">Page 139</p> <p>1 "Did you ever have a discussion with 2 Ms. Atkins that she submitted the wrong codes?" 3 "Once I received the letter from United 4 saying there was information missing, I 5 contacted her and that was it." 6 "So you received the letter from United 7 informing you that something was missing; is 8 that what you said?" 9 "I only contacted her after I received 10 the letter stating that my claim was going to 11 be denied." 12 Do you see that? 13 A. Yes. 14 Q. And does that testimony indicate to you that 15 she understood the core reason for the denial of her 16 claim? 17 A. Yes. She understood that there was missing 18 information. 19 Q. And is that the core reason, that there was 20 missing information? 21 A. Yes. 22 Q. Do you think that she understood that it was 23 her responsibility to provide that information? 24 A. No. I think that -- that it is the 25 responsibility of the provider to provide that</p> | <p style="text-align: right;">Page 141</p> <p>1 her responsibility to send the letters to her provider? 2 A. Well, I don't know what she was told. I'm 3 surprised by that, you know, that in Exhibit 11. It 4 specifically says you're receiving a copy of this letter 5 to -- 6 "Dear Christine Endicott, you're 7 receiving a copy of this letter to keep you 8 informed about the status of this claim. The 9 letter on the reverse side was sent to the 10 doctor, facility or other healthcare 11 professional." 12 Which would be the normal course of action. 13 But I certainly have no knowledge as to whether or not 14 Lori Atkins actually received it. 15 Q. Do you think the language in the letter to 16 Ms. Endicott that says you do not need to respond or 17 take any action at this time initiates a dialogue about 18 her claim with United HealthCare? 19 A. No. That language does not. 20 BY MR. ZIPPERIAN: 21 Q. Let's take a look at -- 22 I think we are on Miller 14 now. 23 (Exhibit 14 was marked for identification.) 24 MR. DEEGAN: The Endicott deposition, that 25 was 13?</p> |

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| <p style="text-align: right;">Page 142</p> <p>1 MR. ZIPPERIAN: I think so.</p> <p>2 THE REPORTER: Yes.</p> <p>3 BY MR. ZIPPERIAN:</p> <p>4 Q. So Miller 14 is deposition testimony of Rachel</p> <p>5 Condry. Do you see that?</p> <p>6 A. Yes.</p> <p>7 Q. At Footnote 18 you reference certain pages of</p> <p>8 her deposition for the proposition that Condry knew her</p> <p>9 provider provided the procedure code to UHG. Do you see</p> <p>10 that in Footnote 18 of your report under that big pile</p> <p>11 of stuff?</p> <p>12 A. I see it.</p> <p>13 Q. What about the deposition testimony that you</p> <p>14 cite, which is 8212 to 8301, indicates to you that</p> <p>15 Ms. Condry knew the core reason for the denial of her</p> <p>16 claim?</p> <p>17 A. Well, let me find --</p> <p>18 Q. And I'm asking specifically about the language</p> <p>19 that you cite.</p> <p>20 A. I've got to find the Condry EOB. Has the</p> <p>21 Condry EOB been put --</p> <p>22 Q. I don't think it had. And you cite this</p> <p>23 language, 8212 to 8301, for the proposition that</p> <p>24 plaintiff understood the core reason for denial of her</p> <p>25 claim, so I'm just wondering what in --</p> | <p style="text-align: right;">Page 144</p> <p>1 A. Yeah.</p> <p>2 MR. DEEGAN: Object to form.</p> <p>3 BY MR. ZIPPERIAN:</p> <p>4 Q. On page 83 she says "Did you understand" -- on</p> <p>5 83, line 15:</p> <p>6 "Did you understand that there was</p> <p>7 something not appropriate about the code that</p> <p>8 was used when you received this?"</p> <p>9 "No. I honestly -- yeah, no."</p> <p>10 A. Well --</p> <p>11 Q. Does that indicate to you that she understood</p> <p>12 the reason why her claim was denied?</p> <p>13 A. No, but that's not what I'm saying. What I'm</p> <p>14 saying is that she did understand that it was the</p> <p>15 provider that was responsible for submitting the code.</p> <p>16 Q. And how does her knowledge that the provider</p> <p>17 was responsible for submitting a code indicate her</p> <p>18 understanding the core reason for the denial?</p> <p>19 A. Well, the core reason for the denial was</p> <p>20 inappropriate code was used and she understands that a</p> <p>21 code was used, that it was not necessarily the correct</p> <p>22 code and that the provider is responsible for supplying</p> <p>23 the correct code. I don't know what more she would need</p> <p>24 to understand.</p> <p>25 Q. And that to you indicates her understanding of</p> |
| <p style="text-align: right;">Page 143</p> <p>1 MR. DEEGAN: Object to the extent that you</p> <p>2 are referring to a document that hasn't been entered as</p> <p>3 an exhibit yet.</p> <p>4 MR. ZIPPERIAN: There is no document that</p> <p>5 hasn't been entered to an exhibit. He doesn't refer to</p> <p>6 the EOB. He refers to the deposition testimony.</p> <p>7 THE WITNESS: Well, in order for me to answer</p> <p>8 the question, I need to know which code was used in the</p> <p>9 EOB for Rachel Condry, because that's what I'm opining</p> <p>10 as to whether or not she understood it.</p> <p>11 BY MR. ZIPPERIAN:</p> <p>12 Q. What about the language that you cite would</p> <p>13 change depending on the code that she --</p> <p>14 MR. DEEGAN: I'll continue my objection.</p> <p>15 THE WITNESS: Well, it's clear, as I assumed,</p> <p>16 that the code that we were -- the denial code that we</p> <p>17 were talking about is the KM code, which indicates that</p> <p>18 there may be more appropriate CPT codes that describes</p> <p>19 the service. And in 82 -- on 82 and 83 there's a</p> <p>20 discussion that -- there's a discussion about the need</p> <p>21 for an appropriate code, which is what I relied on. To</p> <p>22 me that's the core reason.</p> <p>23 BY MR. ZIPPERIAN:</p> <p>24 Q. And that indicates to you that she understood</p> <p>25 the core reason for the denial of her claim?</p> | <p style="text-align: right;">Page 145</p> <p>1 the core reason for the denial of her claim?</p> <p>2 A. Yes.</p> <p>3 Q. And you get that from page 82, line 12 to page</p> <p>4 83, line 1?</p> <p>5 A. Yes.</p> <p>6 MR. ZIPPERIAN: I think we've got DVD issues.</p> <p>7 THE VIDEOGRAPHER: This ends Media 3 in the</p> <p>8 deposition of Dr. Henry Miller. We are off the record</p> <p>9 at 2:01 p.m.</p> <p>10 (Recess held.)</p> <p>11 THE VIDEOGRAPHER: This begins Media 4 in the</p> <p>12 deposition of Dr. Henry Miller. We are on the record</p> <p>13 at 2:13 p.m.</p> <p>14 BY MR. ZIPPERIAN:</p> <p>15 Q. Dr. Miller, I'm going to ask you to take a</p> <p>16 second or a minute to read pages 62, 63 and 68 of Rachel</p> <p>17 Condry's deposition, which is part of Miller 14. Have</p> <p>18 you read that deposition testimony before?</p> <p>19 A. Yes.</p> <p>20 Q. After reading that, do you think that</p> <p>21 Ms. Condry understood the core reason for the denial of</p> <p>22 her claim?</p> <p>23 A. Well, that taken by itself really doesn't</p> <p>24 address it. What we discussed previously were pages 82</p> <p>25 and 83 of her deposition, which were the pages that I</p> |

Page 146

1 referenced. I think that indicates that she understood,
 2 yes, but this does not necessarily.
 3 Q. Do you think that that testimony indicates
 4 that she understood that United HealthCare was trying to
 5 initiate a dialogue about her claim?
 6 A. Well, I -- I -- I can tell you that --
 7 obviously, I can't tell you what she did or didn't
 8 understand, but I can tell you that it says right on the
 9 EOB immediately following the fact that the first claim
 10 was denied, that you have the right to appeal and it
 11 gives the instructions for the appeal. So I can't tell
 12 if she read it or not, but it's right there. United is
 13 providing the communication.
 14 Q. What's your understanding of the types of
 15 claims that these women are making submissions for?
 16 A. My understanding is it's for breastfeeding.
 17 Q. And specifically for issues related to
 18 breastfeeding? Is that your understanding?
 19 A. Yes.
 20 Q. Looking at page 62 of Ms. Condry's deposition
 21 testimony, she's asked:
 22 "How many visits did you have with
 23 Ms. Schwerin?"
 24 Answer is:
 25 "Three."

Page 147

1 "And you or your -- did you submit claims for
 2 the second visit?"
 3 "We had already been denied for the
 4 first visit, and so we didn't at that time seek
 5 the other two because we'd already been denied
 6 the first one."
 7 "Okay. So for Visits 2 and 3, no claim was
 8 submitted by either you or your wife?"
 9 "That's correct. We felt that there
 10 would be no recourse if we had already been
 11 denied."
 12 Do you see that?
 13 A. Yes.
 14 Q. And then on line 19 it says:
 15 "Why did you not appeal the denial of
 16 the claim for the services for the first
 17 visit?"
 18 And her answer is:
 19 "I think at the time we were just really
 20 overwhelmed with what was going on in our lives
 21 and our new daughter. And by that point, you
 22 know, by the time we would have been submitting
 23 those claims, we would have -- both of us would
 24 have been back to work, and it was a very
 25 intense transition."

Page 148

1 Do you see that?
 2 A. Yes.
 3 Q. And later on page 63, line 11, it says:
 4 "Were you aware that you had an option
 5 to appeal the denial?"
 6 And her response is:
 7 "Honestly, I'm not sure we were thinking
 8 about it."
 9 Do you see that?
 10 A. Yes.
 11 Q. And then on page 68, line 2, it says:
 12 "It was a letter that came with the kind
 13 of standard, you know, showing the provider and
 14 the service date and it said den- -- you know,
 15 item not covered. It didn't have -- I always
 16 find those quite perplexing. A lot of times
 17 they refer to a number. In this case it was
 18 whatever reason it was denied, it didn't make
 19 any sense to me. I didn't know why."
 20 Does that indicate to you that she understood
 21 the core reason why her claim was denied?
 22 A. That doesn't indicate it at all, but it
 23 clearly, the section that I referred to, pages 82 and
 24 83, makes it clear that she understands that it was
 25 because an inappropriate code was used.

Page 149

1 Q. I'm going to ask you to read me the specific
 2 language that you think makes it clear to you that she
 3 understood that that was the reason her claim was
 4 denied.
 5 A. She understood that the issue -- and this is
 6 the only reason that I used it -- she understood that
 7 the issue was coding.
 8 Q. I'm just asking you to read the specific
 9 language that you think makes that clear.
 10 A. Well, she says in response to the question
 11 "And did you ask Ms. Schwerin if there was or who
 12 provided the codes for the claim," and she said:
 13 "I'm sure it must have been on Ellen's
 14 invoice."
 15 She knows that a code is involved. She said,
 16 no, she didn't provide the code, but, then, of course,
 17 she wouldn't have.
 18 Q. And that language indicates to you that she
 19 understood the core reason for the denial of the claim?
 20 A. Yes.
 21 MR. ZIPPERIAN: Okay. Are we on 15 now?
 22 This is Miller 15.
 23 (Exhibit 15 was marked for identification.)
 24 BY MR. ZIPPERIAN:
 25 Q. Miller 15 is the deposition testimony of Laura

Page 150

1 Hipple, who is Laura Bishop. And you cite this excerpt
 2 of page 118, line 10 to 119, line 13 for the proposition
 3 that Bishop knew her provider provided the procedure
 4 code to UHG. Do you see that?
 5 A. Yes.
 6 Q. How does the fact that she knew that her
 7 provider provided a procedure code to United HealthCare
 8 support the proposition that she understood the core
 9 reason for the denial of the claim?
 10 A. Well, the core reason for the denial of the
 11 claim was that an inappropriate code may have been used,
 12 and she certainly understood the first part, and it's
 13 not a reimbursable service. And even though she says
 14 she doesn't know what a CPT or HCPCS code is, she trusts
 15 that her providers knows what codes they should or
 16 should not use to provide the service. To me that
 17 indicates that she knew what that code was saying.
 18 Q. And what was it saying?
 19 A. It was saying that potentially an
 20 inappropriate code was used.
 21 Q. So when she says on page 119 in response to
 22 the question, "Okay. And what did that indicate to
 23 you" -- and that's referencing the remark code, her
 24 response is -- "what it meant to me at that time was I
 25 have no idea what all this means, in spite of that, you

Page 151

1 think that she understood the core reason for the denial
 2 of her claim?
 3 A. What I believe is that the language of the
 4 remark code, KM, clearly communicated to her that an
 5 inappropriate code was used. She may not have indicated
 6 she understood that in the sentence you read to me, but
 7 when I read the sentence two sentences later that says
 8 "What I trust is that my providers know what codes they
 9 should use or should not use to describe a service," to
 10 me means that she understood the communication that was
 11 being provided to her.
 12 Q. So the fact that she thinks her providers
 13 should know what codes they should use indicates to you
 14 that she understands the core reason for the denial of
 15 her claim?
 16 A. Sure. The core reason for the denial of the
 17 claim was that an inappropriate code may have been used.
 18 Q. But if somebody doesn't have any understanding
 19 of how codes are used in the healthcare system, then
 20 what does her knowing that her providers or trusting
 21 that her providers should know what codes they should
 22 use indicate that they have an idea about why their
 23 claim is denied?
 24 A. The communication in the KM description says
 25 that an inappropriate code was used. When she says

Page 152

1 Laura Hipple, when she says that she trusts that the
 2 provider understands what code should or should not be
 3 used, she's making it clear that that communication
 4 about codes was effective in what it intended to do,
 5 which was to tell her that was the reason why there was
 6 a denial. I'm not expecting that she would know which
 7 codes to use, nor does she expect it, but she does
 8 understand that an inappropriate code may have been
 9 used.
 10 Q. Let's go back to your report. Do you know the
 11 outcome of the appeals of Felicity Barber and Jance Hoy?
 12 A. No.
 13 Q. Did you inquire about the outcomes?
 14 A. No.
 15 Q. Do you feel -- and I think you've answered
 16 this already, so forgive me if I'm reasking it, but do
 17 you feel that the EOBs encourage consumers to file
 18 appeals?
 19 MR. DEEGAN: Form.
 20 THE WITNESS: I would -- how would you define
 21 encourage?
 22 BY MR. ZIPPERIAN:
 23 Q. Whether they do more than simply provide
 24 information about the appeals process but in fact seek
 25 to drive members towards filing an appeal.

Page 153

1 MR. DEEGAN: Same objection.
 2 THE WITNESS: I don't -- in that context I
 3 don't think that the EOBs encourage or discourage
 4 appeals. That would not be the purpose of the EOB.
 5 The purpose of the EOB in the area that we're
 6 talking about in terms of appeals is to let the member
 7 know that if they feel as though the determination was
 8 not correct, they have multiple ways to address it.
 9 They can file an appeal. They are part of an ERISA
 10 plan. They can address it that way. They can contact
 11 consumer advocates. So I think that it's not a health
 12 insurer's responsibility to encourage or discourage
 13 appeals, but there is a responsibility to let people
 14 know how to do it if they want to.
 15 BY MR. ZIPPERIAN:
 16 Q. And you think United HealthCare EOBs
 17 effectively do that?
 18 A. I do.
 19 Q. On page 9 you state "Whether a given remark
 20 code" -- I'm looking at the third paragraph up from the
 21 top. Starts with "accordingly."
 22 A. Yes.
 23 Q. You state that:
 24 "Whether a given remark code may have
 25 been appropriate or inappropriate in a

| | |
|---|--|
| <p style="text-align: right;">Page 154</p> <p>1 particular situation cannot be determined</p> <p>2 without assessing the surrounding</p> <p>3 circumstances."</p> <p>4 Do you see that?</p> <p>5 A. Yes.</p> <p>6 Q. What surrounding circumstances are you</p> <p>7 referring to?</p> <p>8 A. The circumstances that relate specifically to</p> <p>9 the patient and the patient's claim.</p> <p>10 Q. Which are?</p> <p>11 A. As they indicate in the rest of that sentence:</p> <p>12 "Including the services provided, the</p> <p>13 claims submitted, and the member's</p> <p>14 communications with the provider or UHG."</p> <p>15 Q. Isn't one of the reasons that insurers use</p> <p>16 remark codes is to eliminate the need to assess</p> <p>17 surrounding circumstances?</p> <p>18 A. No.</p> <p>19 Q. Do insurers assess surrounding circumstances</p> <p>20 before issuing a denial based on the use of an incorrect</p> <p>21 code?</p> <p>22 A. No.</p> <p>23 Q. How is a member's communication with a</p> <p>24 provider or United HealthCare relevant to whether a code</p> <p>25 is appropriate?</p> | <p style="text-align: right;">Page 156</p> <p>1 would change the propriety of a used remark code.</p> <p>2 A. Well, the remark code once used is used. It's</p> <p>3 now on the EOB. But if in fact it's not correct, then</p> <p>4 that would be information that the member would submit</p> <p>5 on appeal and it could be changed.</p> <p>6 Q. But the communication wouldn't change the</p> <p>7 circumstances that led to the remark code being used, it</p> <p>8 might change the understanding from United HealthCare</p> <p>9 about why a claim was submitted the way it was</p> <p>10 submitted; correct?</p> <p>11 A. No. No. I think the increased understanding</p> <p>12 could in fact change whether or not the code was</p> <p>13 correct. It wouldn't give them any information</p> <p>14 necessarily about the circumstances for the submission</p> <p>15 of the claim.</p> <p>16 Q. In the next sentence you say again:</p> <p>17 "It is reasonable to expect that members</p> <p>18 will contact their providers in response to</p> <p>19 this denial reason."</p> <p>20 And it's referring to the denial -- the first</p> <p>21 denial statement identified in the court's order which</p> <p>22 is:</p> <p>23 "This is not a reimbursable service.</p> <p>24 There may be a more appropriate CPT or HCPCS</p> <p>25 code that describes the service and/or the use</p> |
| <p style="text-align: right;">Page 155</p> <p>1 A. Well, I think earlier today I indicated that</p> <p>2 when I used the term or the words appropriate or</p> <p>3 inappropriate, I was specifically referring to whether</p> <p>4 the right remark code was used for a specific situation.</p> <p>5 If the member reads that and communicates with their</p> <p>6 provider, the discussion with the provider will help the</p> <p>7 member to understand whether or not that code made sense</p> <p>8 in the context of the service.</p> <p>9 Q. That wouldn't change whether the correct code</p> <p>10 was used, would it?</p> <p>11 A. (No response.)</p> <p>12 Q. The member communication necessarily comes</p> <p>13 about after the code is used, right, or remark code is</p> <p>14 used?</p> <p>15 A. That's correct, but the information obtained</p> <p>16 from the provider could be used in an appeal.</p> <p>17 The purpose of this sentence, I'm not sure</p> <p>18 that you're interpreting it the way in which I meant it</p> <p>19 when I wrote it. What I'm saying is that after the</p> <p>20 remark code is provided, the particular circumstances</p> <p>21 relating to a member are critical to assessing whether</p> <p>22 or not the correct code was used. I'm saying it's</p> <p>23 just -- it's an individualized process.</p> <p>24 Q. And I guess I don't understand how</p> <p>25 communications with a provider or United HealthCare</p> | <p style="text-align: right;">Page 157</p> <p>1 of a modifier or modifier combination is</p> <p>2 inappropriate."</p> <p>3 A. You kind of lost me. Where are you reading</p> <p>4 from?</p> <p>5 Q. The next paragraph down. I'm sorry.</p> <p>6 A. Yes.</p> <p>7 Q. Why is it reasonable to expect that members</p> <p>8 will contact their providers in response to that?</p> <p>9 A. Well, I think we can see that, certainly from</p> <p>10 Laura Hipple's deposition and sort of implied in one of</p> <p>11 the others, I guess Christine Endicott, I'm not sure</p> <p>12 which one it was, that even though they didn't</p> <p>13 understand what a CPT or a HCPCS code was, they did</p> <p>14 understand that the provider was responsible for</p> <p>15 identifying it. And if that's the issue, you would call</p> <p>16 your provider. You would contact your provider to find</p> <p>17 out how to deal with the situation that perhaps the</p> <p>18 wrong code was used.</p> <p>19 Q. Does United HealthCare direct the members to</p> <p>20 contact their providers when they use that remark code?</p> <p>21 A. No.</p> <p>22 Q. Why not?</p> <p>23 A. Sometimes I think it's -- I can't tell you.</p> <p>24 First, I can't tell you why United does or does not do</p> <p>25 that. I didn't ask that question. I don't know the</p> |

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| <p style="text-align: right;">Page 158</p> <p>1 answer to that, but it seems to obvious to me, to me, 2 that would be what you would do. 3 Q. It seems obvious to you that that's what you 4 would do, meaning? 5 A. That's what a member would do. 6 Q. The member would try to contact their 7 provider? 8 A. Right. And, in fact, again, in the case of 9 the Breastfeeding Resource Center, they specifically 10 hand out a sheet of paper that says do that. 11 Q. Doesn't the expectation that a member will 12 contact their provider without any direction to do so 13 assume that the member has an understanding of how the 14 coding system works? 15 MR. DEEGAN: Object to form. 16 THE WITNESS: No. They don't need to 17 understand that, because all they need to understand is 18 that -- what the remark code says, which is an 19 inappropriate code may have been used. They don't have 20 to know all of the details. That's why they would talk 21 to the provider and ask them. 22 BY MR. ZIPPERIAN: 23 Q. But nothing in the remark code says anything 24 about the provider submitting a code. 25 A. But it's pretty clear from, even from the</p> | <p style="text-align: right;">Page 160</p> <p>1 patient wants more information, there's two possible 2 sources to get it at. I mean, that's pretty obvious. 3 But, also, in the EOB, there is a sentence 4 that says: 5 "You or your authorized representative, 6 such as a family member or physician, may 7 appeal the decision by submitting comments, 8 documents or other relevant information to the 9 appeal address referenced above." 10 So, yes, I think that the member is directed 11 to their provider if they have questions. It's not 12 directly related to the remark code, but the EOB 13 indicates that that's a source for them. 14 Q. What in the EOB would indicate to a member 15 that it is the provider's responsibility to submit codes 16 to the health plan? 17 A. Well, once again, the remark code that we're 18 talking about, the KM code, says that an inappropriate 19 code may have been used, and there are only three 20 possible -- well, there are only two possible sources 21 for the submission of a claim, either the patient or the 22 provider. And the patient understands by reading that, 23 certainly communicates clearly, that codes are involved 24 and they know that they didn't submit any codes, so it 25 must have been the provider. There isn't anybody else.</p> |
| <p style="text-align: right;">Page 159</p> <p>1 depositions that we were just referring to a few minutes 2 ago, that it's understood by most people that they know 3 they don't submit the codes. 4 Q. Okay. So we're talking about three 5 depositions? 6 A. Well, three depositions of three plaintiffs in 7 this particular case, yes. 8 Q. Right. What I'm asking about is whether 9 there's any indication in the remark code itself which 10 would lead a member to believe that a provider is 11 responsible for submitting a code or in the EOB 12 generally? 13 A. Well, yes. 14 Q. Show me. 15 A. In the remark itself I don't think that there 16 is a -- 17 Q. What are we looking at here? 18 A. I'm looking at any one of the EOBs. 19 Q. Okay. 20 A. The remark code does not include the sentence 21 you should call your provider. I think that that's 22 something that is obvious. 23 I think I've said before there's only three 24 parties involved in this healthcare claim situation, the 25 patient, the provider and the insurer, and if the</p> | <p style="text-align: right;">Page 161</p> <p>1 Q. Do you think that members necessarily know 2 that there are only three parties involved in the 3 healthcare transaction? 4 A. Yeah. 5 Q. You think that the typical layperson has an 6 understanding of how health insurance works with 7 providers regarding the submission of claims? 8 A. Well, they don't have to know that. I think 9 what they know is that they only have interaction with 10 two other parties, their provider and the insurer. Yes, 11 I think that people understand that. 12 Q. And that's just based on your experience? 13 A. No. I think that's based on common sense. 14 Q. What are CPT code -- what information is 15 reflected in a CPT code? 16 A. CPT code identifies the procedure that is 17 performed on the patient. 18 Q. Would a CPT -- would a claim be returned for a 19 CPT claim not matching the patient's diagnosis? 20 A. Yes. 21 Q. But my understanding is a CPT code does not 22 reflect the diagnosis of the patient. 23 A. That's correct. 24 Q. So explain to me how that would happen. 25 A. Well, if a claim was submitted that indicated</p> |

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| <p style="text-align: right;">Page 162</p> <p>1 that the diagnosis was a heart attack and the procedure 2 code was back surgery, that would certainly be a good 3 example of when the diagnosis on the CPT code did not -- 4 did not mesh or they were not -- the CPT code didn't 5 match the diagnosis. There are certain procedures that 6 are relevant to specific diagnoses.</p> <p>7 Q. And are -- is there something that's automated 8 that correlates those things?</p> <p>9 A. Yes.</p> <p>10 Q. That's the standard procedure for health 11 insurers?</p> <p>12 A. Yes. And if there's a question, what health 13 insurers do is they pull that particular claim out if 14 the automated process doesn't identify it but yet there 15 seems to be a discrepancy, and it's handled manually and 16 individually.</p> <p>17 Q. Do you know if United HealthCare has a process 18 of its insurers that claim denials are sent to 19 providers?</p> <p>20 A. No, I don't. I assume they do. I mean, 21 that's an implication that they do in the cover letter 22 to Christine Endicott which we read before indicating 23 that a letter was sent to the provider, but I don't know 24 anything about that particular process.</p> <p>25 Q. For the second remark code identified in the</p> | <p style="text-align: right;">Page 164</p> <p>1 there are certain codes, CPT codes, or they could be 2 HCPCS codes which are healthcare common -- that's the 3 healthcare common procedure coding system, which is sort 4 of an augmentation of the CPT codes, an extension of 5 them.</p> <p>6 There are codes that are only paid as part of 7 another service. So if a service is normally provided, 8 it is expected that there won't be a separate billing or 9 a separate claim line for that particular code, that it 10 is encompassed in another code. Sometimes that has to 11 do with lab tests. I'm just trying to provide an 12 example where a lab test would be combined with a 13 another procedure.</p> <p>14 But as an individual procedure, a particular 15 code may not be separately reimbursable in some 16 instances. And that's what this remark description 17 relates to. For example, what I was just describing, if 18 a lab submitted it and there was no other service being 19 provided, then it would be separately reimbursable, but 20 if a physician submitted it and it was part of the 21 overall service that was being provided, it would not be 22 paid separately.</p> <p>23 Q. Are United HealthCare members informed that 24 they can challenge the determination that something is 25 not medically necessary by going to the myuhc website or</p> |
| <p style="text-align: right;">Page 163</p> <p>1 order on page 10, the second full paragraph down on page 2 10 --</p> <p>3 A. Yes.</p> <p>4 Q. -- it's:</p> <p>5 "This service code is not separately 6 reimbursable in this setting." 7 Do you see that?</p> <p>8 A. Yes.</p> <p>9 Q. I think we talked about before about what the 10 term separately reimbursable means?</p> <p>11 A. Yes.</p> <p>12 Q. Do you think a layperson would understand what 13 separately reimbursable means?</p> <p>14 A. It's very difficult to answer these questions 15 on understandability because of such a range of -- it's 16 not a precise concept. So it's hard for me to answer 17 whether or not a typical layperson understands the code. 18 I think, though, understands what that means, but I do 19 think that it is clearly communicated. I don't know, I 20 can't think of other wording that would be more -- that 21 would more clearly communicate the point. So I think 22 it's as clearly communicated as it can be.</p> <p>23 Q. Tell me again what separately reimbursable 24 means.</p> <p>25 A. Well, the way I described it before was that</p> | <p style="text-align: right;">Page 165</p> <p>1 calling customer service?</p> <p>2 MR. DEEGAN: Objection. Form.</p> <p>3 THE WITNESS: Well, I don't know that that is 4 relevant to my report. I haven't discussed -- I 5 haven't discussed medical necessity. I don't know 6 where you're coming from with that.</p> <p>7 BY MR. ZIPPERIAN:</p> <p>8 Q. Fair to say that you don't know the answer to 9 that?</p> <p>10 A. Well --</p> <p>11 MR. DEEGAN: Same objection.</p> <p>12 THE WITNESS: I'd like you to repeat the 13 question.</p> <p>14 BY MR. ZIPPERIAN:</p> <p>15 Q. Is a member informed that they can challenge 16 the determination that something is not medically 17 necessary by going to the website or calling customer 18 service?</p> <p>19 MR. DEEGAN: Object to form.</p> <p>20 THE WITNESS: I think the words that you're 21 using make it difficult. What do you mean by 22 challenge? You know, they can call up and ask, but a 23 challenge would be an appeal, and there's certainly 24 enough information to identify the fact that they can 25 appeal.</p> |

Page 166

1 BY MR. ZIPPERIAN:
 2 Q. That's the only way in which a United
 3 HealthCare member can challenge the determination of
 4 medical necessity?
 5 MR. DEEGAN: Same objection.
 6 BY MR. ZIPPERIAN:
 7 Q. Through an appeal?
 8 A. They can challenge it informally, but if they
 9 want to challenge it formally, they have to file an
 10 appeal.
 11 Q. With regards to the second remark code, you
 12 state that:
 13 "The service code referred to is the
 14 CPT/HCPSC code included on the claim form."
 15 Do you see that? The same place we just
 16 were --
 17 A. Yes.
 18 Q. How do you know that the service code is the
 19 CPT HCPCS code?
 20 A. Because that's the definition of a service
 21 code.
 22 Q. How would a member know that?
 23 A. I don't think the member needs to know that.
 24 Q. Do you think the member needs to know what a
 25 service code is?

Page 167

1 A. I think the member needs to understand the
 2 description, and the description says this service code,
 3 whatever it is, relates to a service. I don't know that
 4 they need to know the precise code. That's what is not
 5 being paid and it's because it's not separately
 6 reimbursable. I think that's effective communication.
 7 Q. Would a member be able to submit a service
 8 code without contacting their provider?
 9 A. No. No. The member doesn't submit service
 10 codes. The provider is the one -- they can submit
 11 claims for reimbursement if they're submitting them on
 12 their own and not through a provider, but they wouldn't
 13 necessarily use a service code.
 14 Q. You state:
 15 "The use of this remark code invites the
 16 provider to submit a corrected claim with the
 17 correct information."
 18 Do you see that?
 19 A. Yes.
 20 Q. How does it invite the provider to do that?
 21 A. Well, the provider gets the same information
 22 and the provider is told that the service code is not
 23 separately reimbursable in the setting and the provider
 24 would then know to look to see what the code is; is very
 25 likely to understand what the issue is. That's what

Page 168

1 they do to get paid. And if an incorrect code was used,
 2 then they would submit a corrected claim.
 3 Q. Does that assume that the provider should and
 4 can change the code in order to get reimbursed?
 5 A. Well, can, yes. Should depends -- that
 6 depends on the individual circumstances.
 7 MR. ZIPPERIAN: Let's go ahead and mark this
 8 as Miller --
 9 THE REPORTER: Sixteen.
 10 MR. ZIPPERIAN: Sixteen.
 11 (Exhibit 16 was marked for identification.)
 12 MR. ZIPPERIAN: I think it's the same as an
 13 actual previous exhibit without the sticky note. It's
 14 the same as Miller 12 without the sticky note on the
 15 front, I think.
 16 MR. DEEGAN: Yeah, it looks like it.
 17 BY MR. ZIPPERIAN:
 18 Q. Miller 16 has been previously Bates-numbered
 19 UHC002378 through 2381. Do you see that?
 20 A. Yes.
 21 Q. In your report you testify in the last
 22 paragraph on page 10:
 23 "Based on my review of case materials,
 24 UHG sent Ms. Endicott a letter that also was
 25 sent to her providers specifying the additional

Page 169

1 information sought."
 2 Do you see that?
 3 A. Yes.
 4 Q. Is the case materials you're referring to
 5 there what's now been marked as Exhibit Miller 16?
 6 A. Yes.
 7 Q. Any other case materials that you reviewed?
 8 A. No. That's what I'm specifically referencing.
 9 Q. And is it your opinion that what's been marked
 10 as Miller 16 adequately specifies the additional
 11 information sought from Ms. Endicott?
 12 A. Yes.
 13 Q. What information is specifically sought from
 14 her in this letter?
 15 A. Well, it's in the attachment, in the letter to
 16 Lori Atkins. It specifically says:
 17 "Please provide the following
 18 information, ICD-9 diagnosis code, including
 19 fourth and fifth digit if applicable."
 20 And that's...
 21 Q. Do you think that Ms. Endicott knows what
 22 ICD-9 diagnosis code, including fourth and fifth digits
 23 if applicable means?
 24 A. No, but I don't think she has to. What she
 25 needs to know is that additional information is

Page 170

1 required, and that's what the remark code indicates.
 2 The expectation is that her provider does need to
 3 understand what that is and I'm sure it does understand
 4 it.
 5 Q. So is it your belief that by sending this
 6 letter, United HealthCare puts the impetus or the
 7 resolution of this claim on the provider?
 8 A. Yes.
 9 Q. And does it instruct Ms. Endicott to take any
 10 action in order to assure that her provider submits the
 11 required information?
 12 A. No.
 13 Q. But if the provider fails to submit the
 14 required information, United HealthCare will not pay for
 15 the claim; correct?
 16 A. That's correct.
 17 Q. You state:
 18 "Often it's the providers" --
 19 Same paragraph at the very bottom of page 10/
 20 "Often it is the provider who receives
 21 the request for more information with an
 22 indication of the type of information that's
 23 needed."
 24 Do you see that?
 25 A. Yes.

Page 171

1 Q. What's your basis for that statement?
 2 A. Just my experience in dealing with health
 3 insurers and healthcare claims over 45 years, that's the
 4 way it's done.
 5 Q. How often is often?
 6 A. Very often.
 7 Q. How often is very often?
 8 A. Almost always.
 9 Q. All right.
 10 A. The only reason it says often rather than
 11 universally is that there may be instances, they are not
 12 common, but there may be instances where there's a
 13 request for more information from the member, but in
 14 terms of the kind of information that we're discussing
 15 here as they relate to the remark codes in question,
 16 those would always go to the provider.
 17 Q. On page 11 in the first full paragraph, you're
 18 referring to the Savercool declaration. Do you see
 19 that?
 20 A. Yes.
 21 Q. And it says that:
 22 "A significant number of members do
 23 reach out to UGH after receiving EOBs and that
 24 some obtain adjustments in their claims."
 25 Do you see that?

Page 172

1 A. Yes.
 2 Q. What is the significant percentage?
 3 A. It varies by -- when Savercool presented the
 4 information, it was by remark code and the percentage
 5 varies by remark code as to the percentage reaching out.
 6 And if I'm remembering correctly, it runs from a low of
 7 about 10 percent to a high of about a third of members
 8 who receive those particular remark codes reach out to
 9 UHG.
 10 Q. You also say:
 11 "Some obtain adjustments in their
 12 claims."
 13 A. Yes.
 14 Q. Do you know what percentage that is that
 15 obtain adjustments?
 16 A. No. Again, that varies in terms of the way
 17 the information is presented. It varies for each of the
 18 various remark codes and it's a smaller percentage. It
 19 could be as high as 10 percent for one of the codes, but
 20 it's less for others.
 21 Q. And you say that:
 22 "This data provides additional support
 23 for my opinion that any alleged inadequacy
 24 regarding a denial reason used by UHG in
 25 response to a particular member's claims must

Page 173

1 be assessed on a case-by-case basis in light of
 2 the surrounding circumstances."
 3 How does that data support that position?
 4 A. Well, once the request for information comes
 5 into UHG and once appeals are considered, those are all
 6 investigations and decisions that relate specifically to
 7 the member. And based upon the member's specific
 8 circumstances and coverage and each case is therefore
 9 considered separately and differently. Well, not
 10 necessarily differently, but separately.
 11 Q. Why did you limit your opinion in this report
 12 to the remark codes in the Court's motion for summary
 13 judgment order?
 14 A. That's what I was asked to do.
 15 Q. By defense counsel?
 16 A. Yes.
 17 Q. Again, On page 11 you say:
 18 "In my experience" --
 19 At the very bottom:
 20 "In my experience, payers, such as UHG,
 21 can track when a cost-sharing requirement or
 22 other amount is assessed to a particular
 23 healthcare claim. Payers generally do not
 24 track whether a member was actually charged the
 25 cost share by the provider."

Page 174

1 Do you see that?

2 A. Yes.

3 Q. And you cite the declaration of A. Seay on the
4 top of page 12 for that?

5 A. Correct.

6 Q. Any other support that you have for that
7 proposition?

8 A. Well, again, we talked about my experience in
9 working with health plans on claims processing systems
10 and I would -- based on my experience, it's universal
11 among health insurers, or all the health insurers I've
12 worked with, that they can't track whether co-payments
13 were actually charged or made because that's a
14 transaction between the provider and the patient, and
15 the provider may indicate that there's a co-sharing
16 requirement and the insurer may know that there's a
17 co-sharing requirement, but there's no way to know
18 whether or not the provider actually asked for that from
19 the patient or whether the patient actually paid. Only
20 the provider would know that.

21 Q. What information is contained in United
22 HealthCare's claims records?

23 MR. DEEGAN: Object to form.

24 THE WITNESS: I didn't specifically review
25 United's claims records. I certainly know what's

Page 175

1 included in a claims record, but...

2 BY MR. ZIPPERIAN:

3 Q. Generally speaking, what's in a claims record?

4 A. There's quite a lot of information.

5 Q. Maybe we could short-circuit this and I could
6 ask specific questions.

7 Does a claim rep --

8 MR. DEEGAN: Let's be clear on the record.
9 General, not specific to United Health?

10 BY MR. ZIPPERIAN:

11 Q. Not specific to United HealthCare with the
12 understanding that you have not seen United HealthCare's
13 claims records and these questions are now related to
14 the typical claim record for a health plan in your
15 experience.

16 A. Okay.

17 Q. Do claim records contain information regarding
18 the amount of money a patient paid out of pocket?

19 A. No. No. What the claim record includes is
20 the amount of money that would be required to be paid
21 out-of-pocket based upon the benefits available to the
22 patient and -- but there's no information in the claim
23 record as to whether or not payments were actually
24 made.

25 Q. What about an insured's maximum out-of-pocket

Page 176

1 limit?

2 A. Yeah, there would be information, but it
3 wouldn't necessarily -- there would be some reference to
4 it in the claims record, but it would be difficult to
5 follow there. That would be information that would be
6 included in other records if in fact the member had
7 reached a -- reached their limit. And certainly there's
8 a tracking of that, but the tracking isn't based upon
9 how much they actually paid.

10 When a claim is adjudicated, the insurer
11 identifies an allowed amount, which is what is referred
12 to in the healthcare industry. And that allowed amount
13 includes the amount that the insurance company is going
14 to pay and would be the responsibility of the patient.
15 So when the insurance company is applying an amount to a
16 maximum out-of-pocket limit, they're applying an amount
17 based upon what the member would have paid according to
18 their records, but they don't know if the member
19 actually paid that.

20 Q. They don't have the member's bank records?

21 A. Exactly. Right.

22 Q. What about deductible amounts, would that be
23 in a typical claim record?

24 A. Yeah, that would be part of the
25 determination -- in a typical claim record there would

Page 177

1 be this allowed amount, the amount the insurance would
2 pay and then there would be, depending on the insurer,
3 either an overall total of member responsibility or an,
4 you know, co-pay and other cost sharing could be
5 separate. I've seen it both ways.

6 Q. Is the accuracy of a claim record important to
7 a health plan in order to administer their coverage and
8 benefits?

9 A. Sure.

10 MR. DEEGAN: Objection.

11 BY MR. ZIPPERIAN:

12 Q. Network providers are under contracts with
13 health plans if they are an in-network provider;
14 correct?

15 A. Yes.

16 Q. We established that earlier. Are they allowed
17 to waive required co-pays or deductibles --

18 MR. DEEGAN: Same objection.

19 BY MR. ZIPPERIAN:

20 Q. -- for patients.

21 A. Is who allowed to waive them?

22 Q. A network provider.

23 A. It depends on their contract.

24 Q. Have you examined a United HealthCare's
25 contract with in-network providers?

Page 178

1 A. No.

2 Q. Let's take a look at the conclusions section.

3 In the second sentence of the conclusion paragraph, you

4 say:

5 "UHG points its members to its website,

6 its customer service or the member's provider."

7 How does UHG point its members to the member's

8 provider?

9 A. I think we covered that earlier in the review

10 of the EOB where it indicates that all the EOBs say the

11 same thing here:

12 "Your authorized representative, such as

13 a family member or physician, may appeal the

14 decision by submitting comments, documents or

15 other relevant information to the appeal

16 address referenced above."

17 Q. And it's your testimony that that is United

18 HealthCare directing a member to their provider?

19 A. Yes.

20 Q. Any other ways in which United HealthCare

21 directs its members to their providers?

22 A. Not explicitly, but -- and, of course, they

23 may direct them to their provider, may direct members to

24 their provider on the basis of phone calls and website

25 determinations. All of this is possible. But as far as

Page 179

1 the information that I examined, which was, primarily

2 was the EOB, that would be the only place.

3 Q. Do you have any opinions with regards to this

4 case that haven't been expressed either today or in your

5 reports?

6 A. We didn't discuss my earlier report very much

7 today. So there are opinions in there, but my reports

8 include all of my opinions.

9 Q. Have you examined any of the other expert

10 reports produced either by defendants or plaintiffs in

11 this case?

12 A. No.

13 MR. ZIPPERIAN: I don't have any further

14 questions unless there are follow-up questions.

15 MR. DEEGAN: Can I have about ten or so

16 minutes?

17 MR. ZIPPERIAN: Yes.

18 THE VIDEOGRAPHER: Off the record at

19 3:07 p.m.

20 (Recess held.)

21 THE VIDEOGRAPHER: We are on the record at

22 3:22 p.m.

23 ///

24 ///

25 ///

Page 180

1 EXAMINATION

2 BY MR. DEEGAN:

3 Q. Dr. Miller, I'm just going to ask you a few

4 questions following up on a few things plaintiffs'

5 counsel had.

6 Early on today plaintiffs' counsel asked you

7 whether you had experience testifying with respect to

8 breastfeeding or lactation issues, and I believe you

9 testified that you had not. My question is: In your

10 work as a consultant and in the healthcare industry for

11 over 40 years, have you been asked to address issues

12 related to maternal care or breastfeeding or child care?

13 A. Yes. Actually, in several instances. One

14 project that I completed for the federal government, the

15 Health Resources and Services Administration, was the

16 development of what is probably best described as a

17 diary for pregnant women and their infants through Age

18 1, so from the onset of pregnancy to the first birthday

19 of their infants. This diary was created primarily for

20 low income women. It was widely distributed at the time

21 primarily through community health centers and it

22 included a considerable amount of direction and support

23 for briefing. It was a key component of the diary. And

24 the diary was established in such a way that the woman

25 who is using it could record doctor visits, record

Page 181

1 height, weight, other measures as well as record

2 progress in specific activities like breastfeeding.

3 I also worked on a number of projects for the

4 Bureau of Maternal Child Health Services, also as a

5 health resource and services administration, relating to

6 innovative programs, including a couple of different

7 programs relating to efforts to encourage women to

8 breastfeed.

9 And one other project that I would mention is

10 one that I did for the State of New Jersey for their

11 Department of Health in which they created a network of

12 providers specifically for women who were on Medicaid

13 who were pregnant. The same sort of thing, from the

14 onset of their pregnancy through the first year of their

15 child's life. They were considered to be members of

16 this entity that was created by the State. And I

17 developed a lot of the materials that were used to

18 support the program.

19 Q. And by materials what do you mean?

20 A. I mean directions on when to seek care, why

21 seeking care is important, what kinds of issues relating

22 to your infant you should be most concerned about and

23 the importance of breastfeeding.

24 Q. So breastfeeding or lactation services would

25 have been accounted for by in your development in each

Page 182

1 of these programs?

2 A. Yes.

3 Q. Take a look at what we marked as Exhibit 12,

4 the -- you have it previously marked as Exhibit 12.

5 It's the Endicott November 26, 2015 letter.

6 A. Yes.

7 Q. Okay. Now, I know you familiarized yourself

8 with this document earlier. If you want to take a

9 moment to look at it again. Draw your attention to the

10 first page. It looks like there's a square. Do you see

11 that?

12 A. Yes.

13 Q. What may have been a Post-it note. And I

14 believe plaintiffs' counsel read it out, and I looked

15 for a cleaner copy and I agree with plaintiffs'

16 counsel's recitation, which is:

17 "I called to UHG about this" -- arrow --

18 "I was" -- the sign arrow -- "I was told I was

19 supposed to send this to Lori."

20 Do you see that language?

21 A. I do.

22 Q. In light of the -- first of all, how do you

23 interpret that note?

24 A. Well, I interpret it as meaning that Christine

25 Endicott understood that by being able to have and read

Page 183

1 the letter to Lori Atkins, her provider, that there was

2 a need for more information to be able to resolve her

3 claim.

4 Q. But there was some inadequacy based on medical

5 information?

6 A. Yes. Additional medical information was

7 required.

8 Q. All right. And if you'll look at what had

9 been designated as Exhibit 7, the Endicott EOB.

10 A. I'm sure I'll find it.

11 Q. Do you see that on page 2 of 4 -- and, again,

12 we discussed -- I'm sorry. You discussed this earlier

13 with plaintiff counsel, the remark code B5?

14 A. It may take me a minute to find it here. Got

15 it.

16 Q. I was referring to page 2.

17 A. Right.

18 Q. This is remark code B5?

19 A. Yes.

20 Q. This remark code indicates that additional

21 information was requested?

22 A. Yes.

23 Q. And not received?

24 A. Yes.

25 Q. At least as of December 15, 2015?

Page 184

1 A. Yes.

2 Q. The date on there?

3 A. Yes. That's precisely what it says.

4 Q. And in conjunction with the note on the front

5 of what's Exhibit 12, is it your opinion that Christine

6 Endicott understood that there was missing information

7 from her claim?

8 A. That is my understanding. And the dates match

9 as well because on the October -- on the October 29th

10 letter there's an indication that if there's no response

11 within 45 days.

12 Q. Just for the clarity of the record, if you

13 could just say which exhibit that is.

14 MR. ZIPPERIAN: I believe that's Miller --

15 THE WITNESS: It's Endicott 58.

16 MR. ZIPPERIAN: Which is Miller 11.

17 THE WITNESS: And Miller Exhibit 11. There's

18 an indication at the end of the letter that if there's

19 no response within 45 days, the claim will need to be

20 denied, and that December 15th resolution is just a

21 little over 45 days later.

22 BY MR. DEEGAN:

23 Q. And I guess we can stay on what we were

24 looking at as Exhibit 7. All right. That's the

25 Endicott EOB. You've testified today that at the top,

Page 185

1 starting on page 2 -- and I would suggest you can agree

2 or correct me if I'm wrong. At the top of page 3 and 4

3 there are -- there's a statement:

4 "Have more questions about your claim?

5 Visit www.myuhc.com."

6 Do you see that?

7 A. Yes. And it's also on the first page.

8 Q. On the first page as well?

9 A. On the cover sheet.

10 Q. And there's a phone number on the left-hand

11 side also?

12 A. Yes.

13 Q. I would also draw your attention, in addition

14 to those items -- I'm sorry. And in your opinion

15 those -- that information helps establish or initiate a

16 dialogue between the recipient of the EOB and UHC?

17 A. Yes.

18 Q. Okay. If you turn to page 3 of 4 of that same

19 document, about halfway down the page you'll see a

20 statement section titled "Meet your needs online." Do

21 you see that?

22 A. Yes.

23 Q. Would you mind reading the sentence under that

24 into the record, please?

25 A. "At almost any time day or night,

Page 186

1 you can review claims, check eligibility,
 2 locate a network physician, request an I.D.
 3 card, refill prescriptions, if eligible, obtain
 4 more information on EOB content and more.
 5 For immediate secure self-service, visit
 6 www.myuhc.com."
 7 Q. Is it your opinion that that statement
 8 supports the -- your conclusion that there's -- the EOB
 9 seeks to initiate a dialogue about a claim?
 10 A. Yes. That clearly is intended to initiate a
 11 dialogue.
 12 Q. I'm sorry. Including about obtaining
 13 additional information on an EOB?
 14 A. Yes.
 15 Q. And the remark codes are content that is
 16 contained in the EOB?
 17 A. Yes.
 18 Q. In your EOBs -- I guess we can stay on this
 19 document -- included a procedure to initiate an appeal;
 20 correct?
 21 A. Correct.
 22 Q. Based on your experience in the healthcare
 23 industry, are appeals initiated uniformly by people with
 24 denied claims?
 25 A. No.

Page 187

1 Q. And based on your experience in the healthcare
 2 industry, why not?
 3 A. Well, because each person's case is different.
 4 Each member of a health plan has different issues that
 5 are going to affect their appeal and different issues
 6 regarding the services they receive, the coverage they
 7 receive, the information included in a claim. All of
 8 that is unique to an individual.
 9 The problem is that when a health plan has
 10 millions of claims to process regularly, it needs a
 11 process that at least allows a portion of those claims
 12 to not have to be addressed individually. But when
 13 appeals are created, each one of them has to be
 14 addressed individually to assess the specific
 15 circumstances affecting the appeal.
 16 Q. And so in your -- based on your experience, if
 17 we look at page 2 of 4 of Exhibit 7, the statement "You
 18 or your authorized representative, such as a family
 19 member or physician may appeal the decision by
 20 submitting comments, documents or other relevant
 21 information to the appeal address referenced above,"
 22 does that statement address the individual nature of
 23 appeals?
 24 A. It definitely does. It represents the need
 25 for the members appealing to build a file that

Page 188

1 recognizes their specific issues.
 2 Q. And do you believe that it also addresses the
 3 individual nature of a dialogue that would be created by
 4 an EOB, such as, for example, the one we see at
 5 Exhibit 7?
 6 MR. ZIPPERIAN: Object to the form of the
 7 question.
 8 THE WITNESS: Yes, definitely.
 9 MR. DEEGAN: No further questions.
 10 MR. ZIPPERIAN: I don't have any further
 11 questions.
 12 I have a standing order.
 13 MR. DEEGAN: We would like a rough, if we can
 14 get a rough. We will take the standing order for the
 15 regular transcript and the rough expedited. I don't
 16 know what phrase you guys use.
 17 THE REPORTER: Did you want a rough also?
 18 MR. ZIPPERIAN: Yes.
 19
 20 (The deposition concluded at 3:37 p.m.)
 21
 22
 23
 24
 25

Page 189

1 SIGNATURE OF THE WITNESS
 2
 3 I, HENRY MILLER, Ph.D., the witness in the above
 4 deposition, do hereby certify that I have read the
 5 foregoing deposition taken on January 11, 2019, and that
 6 the said deposition is a true and correct record of my
 7 testimony, with such corrections and changes, if
 8 necessary, attached.
 9
 10 _____
 11 HENRY MILLER, Ph.D. Date
 12 (IF THERE ARE NO CHANGES, WRITE "NONE" BELOW.
 13 PLEASE RETURN THIS WITHIN 30 DAYS OF RECEIPT OF
 14 DEPOSITION TRANSCRIPT.)
 15 PAGE LINE READS CHANGE TO REASON
 16 _____
 17 _____
 18 _____
 19 _____
 20 _____
 21 _____
 22 _____
 23 _____
 24 _____
 25 _____

1 UNITED STATES DISTRICT COURT)
)
2 FOR THE CENTRAL DISTRICT OF CALIFORNIA)

3

4 I, Helen Pasewark, CR No. 50905, CSR No. 6612,
5 Certified Shorthand Reporter, certify:

6 That the foregoing proceedings were taken
7 before me at the time and place therein set forth, at
8 which time the witness was put under oath by me;

9 That the testimony of the witness, the
10 questions propounded, an all objections and statements
11 made at the time of the examination were recorded
12 stenographically by me and were thereafter transcribed;

13 That a review of the transcript by the
14 deponent was not requested:

15 That the foregoing is a true and correct
16 transcript of my shorthand notes so taken.

17 I further certify that I am not a relative or
18 employee of any attorney of the parties, nor financially
19 interested in the action.

20 I declare under penalty of perjury under the
21 laws of California that the foregoing is true and
22 correct.

23 Dated This 18th day of January, 2019.

24 *Helen Pasewark*

Helen Pasewark

25 CR No. 50905, CSR No. 6612, RPR

| Exhibits | | |
|------------------------|-----------------------|-----------------------|
| | 10 26:4 127:5,7,9,12 | 2009 26:22 |
| | 135:17 136:5 150:2 | 2011 20:6 25:15 26:16 |
| | 163:1,2 168:22 | 27:18,22 |
| | 170:19 172:7,19 | 2012 37:7,9 |
| EX 0001 Henry Miller 0 | 10:03 42:14 | 2013 36:17 |
| 11119 3:10 12:23,25 | 10:11 42:18 | 2014 36:17 |
| EX 0002 Henry Miller 0 | 11 5:2,13 12:23 39:17 | 2015 37:12 78:9 |
| 11119 3:11 78:5,7 | 129:13,14,17,21 | 130:12 182:5 183:25 |
| EX 0003 Henry Miller 0 | 130:10 131:7,17 | 2016 37:12 |
| 11119 3:13 | 134:4 135:9,11 141:3 | 2017 52:16,20 53:2 |
| EX 0004 Henry Miller 0 | 148:3 171:17 173:17 | 2018 12:23 29:24 |
| 11119 3:14 | 184:16,17 | 39:17 |
| EX 0005 Henry Miller 0 | 110 90:4 100:5 | 2019 5:2,13 |
| 11119 3:16 96:20 | 1100 5:3,12 | 21 19:4 30:1 |
| EX 0006 Henry Miller 0 | 118 150:2 | 21st 52:16,20 |
| 11119 3:18 | 119 150:2,21 | 22 19:8 140:4 |
| EX 0007 Henry Miller 0 | 11:12 77:23 | 22nd 78:9 |
| 11119 3:20 130:2 | 11:22 78:2 | 23 39:6 136:15 |
| 183:9 184:24 187:17 | 12 26:4 129:13,14,17, | 137:13,15 |
| 188:5 | 21 130:11,23 131:7, | 2381 168:19 |
| EX 0008 Henry Miller 0 | 17,25 135:1 140:5 | 24 135:1 |
| 11119 3:22 | 145:3 168:14 174:4 | 25 22:23 134:24 135:2 |
| EX 0009 Henry Miller 0 | 182:3,4 184:5 | 136:16 |
| 11119 3:24 87:3 | 12:10 106:17 | 2575 5:3,11 |
| EX 0010 Henry Miller 0 | 12:53 106:20 | 26 182:5 |
| 11119 4:3 127:5 | 13 55:14 128:9 | 26th 130:12 |
| EX 0011 Henry Miller 0 | 134:19,20,22 141:25 | 29 20:24 |
| 11119 4:5 134:4 141:3 | 150:2 | 29th 184:9 |
| 184:17 | 14 134:24 141:22,23 | 2:01 145:9 |
| EX 0012 Henry Miller 0 | 142:4 145:17 | 2:13 145:13 |
| 11119 4:7 182:3,4 | 15 17:6 23:10 83:3, | |
| 184:5 | 12,23 89:12 144:5 | <u>3</u> |
| EX 0013 Henry Miller 0 | 149:21,22,23,25 | |
| 11119 4:9 134:20 | 183:25 | 3 77:25 83:4,7 86:25 |
| EX 0014 Henry Miller 0 | 15th 130:5 184:20 | 96:20 108:1 128:15 |
| 11119 4:10 141:23 | 16 168:11,18 169:5,10 | 145:7 147:7 185:2,18 |
| EX 0015 Henry Miller 0 | 18 136:5 142:7,10 | 30 137:13,15,18,19 |
| 11119 4:12 149:23 | 19 13:3,5 26:1 147:14 | 32 140:4 |
| EX 0016 Henry Miller 0 | 1971 13:10 | 33 140:4 |
| 11119 4:13 168:11 | 1987 14:23 | 350 29:10,11 |
| | 1989 14:23 | 36 135:9 |
| <u>\$</u> | | 37 134:24 135:9 |
| \$50,000 39:15 | <u>2</u> | 39 136:15 |
| <u>1</u> | | 3:07 179:19 |
| 1 12:23,25 13:2 26:2 | 2 42:16 54:7 77:21 | 3:22 179:22 |
| 39:17 42:12,21 44:18 | 78:4,5,7,12 147:7 | 3:37 188:20 |
| 52:14 55:13 84:6 | 148:11 183:11,16 | |
| 145:4 180:18 | 185:1 187:17 | |
| | 2/15 135:13 | |
| | 20 16:12 22:10 | |

| | | |
|---|---|--|
| <hr/> 4 <hr/> | <hr/> 8 <hr/> | 134:2 135:5 141:12, 17 170:10 actions 112:17 active 11:10,12 16:21 activities 15:3 17:18 181:2 acts 72:23 actual 38:5 74:16 116:23 168:13 add 117:11 addition 74:23 89:22 185:13 additional 12:2 59:8 60:4,25 61:18,20 74:24 81:12 120:10 121:17 122:3 128:7, 15 130:17 132:17,19, 20 133:6,7,8,10,15, 17 168:25 169:10,25 172:22 183:6,20 186:13 address 57:22 93:19 108:18 109:15,18,23, 25 110:2,3,4 135:3 145:24 153:8,10 160:9 178:16 180:11 187:21,22 addressed 30:7 117:18 131:17 133:20 134:7 135:13 140:14 187:12,14 addresses 49:16 110:12 188:2 addressing 40:8 adds 117:7 adequately 169:10 adjudicated 57:7 176:10 adjudication 60:6 123:7 adjustment 112:14,16 123:6 adjustments 171:24 172:11,15 administer 177:7 administration 13:18 180:15 181:5 adopt 113:18 advance 103:15 advent 57:5 |
| 4 67:7 68:23 72:1 74:25 83:5 90:3 91:7 100:4,6,22 135:9 145:11 183:11 185:2, 18 187:17 40 39:22 135:16 180:11 40- 39:15 400 5:16 41 135:17 136:5 42 135:17 45 65:14 130:19 134:4 171:3 184:11,19,21 | 8 83:6,7 91:23 123:19 128:14 82 143:19 145:3,24 148:23 8212 142:14,23 83 143:19 144:4,5 145:4,25 148:24 8301 142:14,23 85016 5:12 876 78:11 877 108:5,6,7 887 108:4 888 888-8888 84:6 8:57 5:2,13 | |
| <hr/> 5 <hr/> | <hr/> 9 <hr/> | |
| 5 75:25 76:1 83:5 91:22 92:4 93:13 96:20 106:24 108:3,7 109:11 50 17:8,12 25:23 39:22 50/50 28:14 5757 5:15 58 129:18,20 135:10 184:15 59 129:18,21 134:25 | 9 86:24 87:3,5 127:2 137:15,18,19 153:19 | |
| <hr/> 6 <hr/> | <hr/> A <hr/> | |
| 6 55:13 83:5 91:22 100:7 114:10,17,19 120:5 60 16:4 135:20 62 145:16 146:20 63 145:16 148:3 68 20:4 25:15 145:16 148:11 | a.m. 5:3,13 42:14,18 77:23 78:2 absent 65:15 72:23 ACA 33:12 34:4,14 academic 41:16,19 accepted 54:13 access 89:10 accordance 37:17 accountant 14:4 accounted 181:25 accounting 13:6,15,24 accounts 88:21 accreditation 11:25 accuracy 177:6 accurate 14:23 27:17 85:6 93:16 137:23 138:2,3 140:25 accurately 95:15 104:25 acknowledges 127:14 acronym 9:16 Act 21:4 action 26:7,11 37:11 108:12 132:13 133:24 | |
| <hr/> 7 <hr/> | | |
| 7 83:6 91:22 114:15 130:2 183:9 184:24 187:17 188:5 | | |

| | | |
|--|---|--|
| <p>advices 123:10,11 advise 103:20 advised 110:24 advocates 153:11 Aetna 51:5,9,12,16,23 affect 63:12 187:5 affecting 187:15 affects 63:15 Affordable 21:4 Age 180:17 agree 5:18 9:12,21 91:23 98:7 182:15 185:1 agreement 46:11 ahead 7:16 12:22 78:3 82:25 86:23 134:18 168:7 align 76:3,12,18 alleged 172:23 Allen 30:4 allowed 37:2 176:11, 12 177:1,16,21 allowing 95:7 amount 15:25 20:15 28:10,19 78:15,16 105:18 173:22 175:18,20 176:11,12, 13,15,16 177:1 180:22 amounts 176:22 analyses 111:15 analysis 40:3,4 analytics 15:6 analyzed 21:17 22:2 and/or 79:9 156:25 anecdotal 66:13 Angelica 19:12 answering 82:7 answers 6:25 106:7 Anthem 12:14,16,19 anticompetition/ antitrust 35:1 Anton 5:16 anymore 14:6 appeal 36:25 37:1 57:25 70:16 80:3 92:6,10,11,16,25 93:2,6,14,22,25 94:2,14,15,17,18 95:12,16,25 96:3,5,</p> | <p>14 108:10,15,17 109:13,15 110:9 119:20 120:2 146:10, 11 147:15 148:5 152:25 153:9 155:16 156:5 160:7,9 165:23,25 166:7,10 178:13,15 186:19 187:5,15,19,21 appealing 127:15,23, 25 187:25 appeals 37:11,15 92:23 95:7 97:1 108:24 110:4 129:10 152:11,18,24 153:4, 6,13 173:5 186:23 187:13,23 Appendix 13:4 applicability 21:4 applicable 113:23 169:19,23 applies 110:10 apply 6:22 21:16 77:2 applying 176:15,16 approaches 62:12 appropriately 104:25 approved 27:11,13,16 Approximately 8:17 10:22 20:1 27:24 41:13 approximation 25:17 39:13,15 area 31:5,9,15 35:17 58:9 153:5 areas 26:2 arise 23:17 arisen 23:11 Arizona 5:4,5,12 array 11:22 15:14 arrow 182:17,18 articulating 91:12 Ashlie 39:6 aspects 66:6 assess 154:16,19 187:14 assessed 173:1,22 assessing 154:2 155:21 assignment 45:22 52:15</p> | <p>assignments 25:1 30:8 assist 39:23 assistance 108:23 assume 7:16 52:21,24 59:18 62:16 90:20 158:13 162:20 168:3 assumed 143:15 assuming 54:18 65:7 89:7,9 122:9 assure 170:10 Atkins 135:14 136:2 138:24 139:2 140:7 141:14 169:16 183:1 attachment 169:15 attack 162:1 attempt 7:12 attention 31:16 117:14 182:9 185:13 attorney 102:23 attorneys 10:5,23 11:5 52:24 audible 6:25 audio 5:17 augmentation 164:4 August 52:16,20 53:2 authorized 108:14 109:12 119:19 160:5 178:12 187:18 automate 61:8 automated 162:7,14 automatic 60:9 average 35:10 aware 36:9 39:2 48:14 62:7 101:23 103:24 134:14 148:4</p> <hr/> <p style="text-align: center;">B</p> <hr/> <p>B5 55:14 120:6 130:5 137:2 183:13,18 back 23:10 26:1 33:1, 15 37:3 52:14 58:21 67:7 74:25 89:12 106:22 140:18 147:24 152:10 162:2 background 13:5 balance 48:9 bank 176:20 Bankers 29:25</p> |
|--|---|--|

| | | |
|---|--|---|
| <p>Barber 92:1 127:7,20 128:25 129:7 152:11 Barber's 127:15 based 36:9 53:6,10,15 60:9 89:9 94:11 122:9 135:12 154:20 161:12,13 168:23 173:7 174:10 175:21 176:8,17 183:4 186:22 187:1,16 basic 40:3 basing 128:21 basis 17:13 31:25 36:5 49:2 57:18 65:24 66:15 68:2 76:17 99:6,18 100:15 107:8 119:14 124:13 127:16,24,25 129:1 171:1 173:1 178:24 Bates 127:8 Bates-numbered 78:11 108:3 168:18 began 30:17 begin 7:13 86:12 93:1 beginning 5:20 85:11 begins 42:16 66:20 77:25 145:11 behalf 5:23,25 18:9, 11,20 30:4 36:21,22 belief 36:5 97:20 113:24 125:2,11 170:5 believed 91:19 believes 114:2 believing 65:24 66:15 110:6 benefit 47:4,5,9,25 48:1,13,14 80:7 91:3 118:22 benefits 11:23 23:25 41:1 45:22 47:10 57:23 78:8 120:8 175:21 177:8 Berkeley 15:7 16:6 17:3,5 28:15,17,20 29:7 34:13 39:8 big 142:10 bill 116:9 billed 78:16,17 billing 9:5 21:9 164:8</p> | <p>binary 49:10 birthday 180:18 Bishop 150:1,3 bit 18:19 34:7 blank 45:15 Blue 12:14,16,19 19:6 22:6,7,8,9,16,17,20 36:20,22 37:25 38:1 47:17 51:7,13,20,24, 25 60:23 board 14:12,13,17,25 bonus 28:25 booklet 47:10,25 booklets 48:1,13,14 books 41:16 bottom 17:6 19:5 170:19 173:19 Boulevard 5:16 box 92:12 93:15 109:23 branch 111:11 break 8:1,2,3,5,7 106:13 breaks 110:22 breastfeed 181:8 breastfeeding 91:18 99:23,24 119:2 127:16,22 129:4 146:16,18 158:9 180:8,12 181:2,23,24 briefing 180:23 bring 28:25 29:2 117:13 broad 15:14,21 31:9 39:14 112:22 broader 105:9 112:8 broadest 53:13 build 187:25 bulk 16:13 bullet 26:4,7 bundled 75:8 Bureau 111:12 181:4 business 13:18</p> <hr/> <p style="text-align: center;">C</p> <hr/> <p>CAHQ 112:3 calculated 29:1 California 5:16 36:20,23,25 37:19,23</p> | <p>38:1 California's 37:25 call 10:11 57:24 70:15 75:22 80:24 81:22 84:1,24 85:13 94:1 96:2,10,22 98:4,6,13 100:10 106:4 117:18 119:4, 9,11 124:14 125:3,5 157:15 159:21 165:22 called 11:6 16:11 25:11 111:13 118:6 131:1 140:10,19 182:17 calling 165:1,17 calls 10:12,15,18,22 62:5 110:21 119:11, 15 178:24 Camelback 5:3,11 capacity 15:9 33:13 Capital 19:6 capture 95:15 captured 24:8 CARC 112:13,14 120:21 121:7,24 122:16,23 123:6 card 186:3 care 21:4 54:19 180:12 181:20,21 case 8:12 9:6 12:14, 16,20 18:13,14,17 19:4,5,10,17,21 25:25 26:18,19,21 27:11,12,25 29:19,24 30:1,3,12,21 33:4,6, 7,23 34:1,8 36:18,25 37:3,5,21,22 38:12, 13,22 39:4,9,25 40:1,4,11,14 41:24, 25 43:12,15 45:6 46:12 48:19,22 50:15,19 52:17,23 53:22 55:9,16 58:21 60:22 61:1,23 68:9 70:8 84:20 92:2,8 96:12 99:15 104:16 114:3,6 118:1 122:25 125:12 148:17 158:8 159:7 168:23 169:4,7 173:8 179:4,11 187:3 case-by-case 173:1</p> |
|---|--|---|

| | | |
|---|--|--|
| <p>case-related 42:24 cases 11:12,13,21 12:4,7,12,13 15:13, 17 18:6,24 19:2,16, 19 20:4,10,11,13,16, 21,22,23,25 21:6 25:15,18,20,21,23,24 26:14,17,25 27:5,8, 10,15 28:4,7,8,9 29:21,22,23 30:13,23 34:7,8 37:19 38:17 40:11 43:20 47:16,21 category 15:12 51:24 caution 8:19 12:1 CCR 5:4 CCRR 5:5 center 16:11,15,21 85:9 99:24 110:11 119:2 129:4 158:9 Center's 91:18 centers 76:5 180:21 Central 36:19 37:23 certification 26:8, 11,21 27:1,4,8,10, 12,16,19,22 certifications 14:2 certified 5:5 6:1 14:4 cetera 69:2 chair 15:2 chaired 14:13 chairman 14:17,22,25 challenge 164:24 165:15,22,23 166:3, 8,9 change 24:5 143:13 155:9 156:1,6,8,12 168:4 changed 37:17 53:2 156:5 charge 108:19 135:12 charged 173:24 174:13 charges 38:4 chart 114:10 115:8 116:14 122:13,14,15 123:19 check 103:19 186:1 child 180:12 181:4 child's 181:15 children 37:24</p> | <p>Children's 36:19 37:22 38:2,3 choice 76:25 119:8 choose 138:6,7 chose 115:11 138:10 Christina 134:23 Christine 91:25 130:5 131:21 132:1 133:14 141:6 157:11 162:22 182:24 184:5 CIGNA 51:5,10,12,17, 24 89:12,21 circled 140:18 circumstances 33:2 60:10 63:2 154:3,6, 8,17,19 155:20 156:7,14 168:6 173:2,8 187:15 cite 82:21 83:11 126:25 131:5 142:14, 19,22 143:12 150:1 174:3 City 13:11,16 92:12 93:15 civil 108:12 claim 23:9 55:6 56:22,24 57:1 58:23 59:11,17,25 60:6,8, 13,24 61:2,22 65:10 69:5,17,24 70:1,2,9, 12,17 71:14,16,17, 21,22 72:2 78:13,22, 23,25 79:16 80:6,7 82:12 85:4,11,13,25 86:15,21 89:17 90:25 91:13 93:20 98:9 100:11 107:17 108:9, 20 109:22 110:9 117:17 119:6 127:20 131:23 133:12 134:6, 9 135:24 136:9 137:23 139:10,16 141:8,18 142:16,25 143:25 144:12 145:1, 22 146:5,9 147:7,16 148:21 149:3,12,19 150:9,11 151:2,15, 17,23 154:9 156:9,15 159:24 160:21 161:18,19,25 162:13, 18 164:9 166:14 167:16 168:2 170:7,</p> | <p>15 173:23 175:7,14, 17,19,22 176:10,23, 25 177:6 183:3 184:7,19 185:4 186:9 187:7 claims 21:24 23:23 36:1,2,6,8 47:18 53:17 54:3 56:6,10, 12,17 57:7,12,16 58:11,13 61:1,6 62:2,9 65:5,22 66:9, 11,12,16 71:2,8,19 82:17 88:13 90:16 98:20 99:2,5,14 100:8 101:7 104:13, 19,24 105:11,18 112:14,17 119:3 123:6,7 127:15,22 129:23 146:15 147:1, 23 154:13 161:7 167:11 171:3,24 172:12,25 174:9,22, 25 175:1,3,13 176:4 186:1,24 187:10,11 clarity 35:10 44:22 47:1,12 100:3 117:7, 11 128:13 184:12 class 26:7,11,20 27:1,3,8,10,12,16, 18,22 classes 127:23 128:1, 5,17 classification 127:24 classified 127:23 128:1,5 cleaner 182:15 clear 7:5 38:14 48:8 57:4 64:21 70:8,16 78:21 79:24 84:22,25 85:2 91:12 125:16 126:6,13,24 128:20, 21 130:20 143:15 148:24 149:2,9 152:3 158:25 175:8 client 22:23 23:6 26:23 32:22 46:3 clients 22:1,4 30:10 closer 42:4 closest 16:20 121:25 CLR 5:4 CMS 50:23 51:10,15 52:6 54:23 68:7</p> |
|---|--|--|

| | | |
|---|---|--|
| 76:6,12,19,22,23 77:5,10 116:5,8 CMS/X12 114:12 co-pay 177:4 co-payments 174:12 co-pays 177:17 co-sharing 174:15,17 code 24:8 49:13 55:14 57:21 58:15 59:10 61:9 62:20,22 63:1, 6,8,9,12,18,22,24,25 64:4,10,11,17,22,25 66:22 67:1,13 69:9, 22,23 70:1,5,19,22 72:3,9,13,18,20,22 73:14,17,19 75:1 76:8,19 77:12,17 79:3,4,9 80:12,16,21 84:11,16 91:12 98:12,13 106:1,2 111:25 112:2 114:12, 15,19 115:3 116:7, 15,19,20,25 117:1,2, 3,6 120:6 121:22,24, 25 122:23 123:16,24 124:15,20 126:3 128:9,25 130:6 137:2 138:14,16 142:9 143:8,13,16,17,21 144:7,15,17,20,21, 22,23 148:25 149:15, 16 150:4,7,11,14,17, 20,23 151:4,5,17,25 152:2,8 153:20,24 154:21,24 155:4,7,9, 13,20,22 156:1,2,7, 12,25 157:13,18,20 158:18,19,23,24 159:9,11,20 160:12, 17,18,19 161:14,15, 16,21 162:2,3,4,25 163:5,17 164:9,10,15 166:11,13,14,18,19, 21,25 167:2,4,8,13, 15,22,24 168:1,4 169:18,22 170:1 172:4,5 183:13,18,20 code/type 116:8 codes 21:9,12,13,17 22:3,5 23:9,15,18,21 24:3,5,24 25:7,12,13 31:12,14,16,21 32:1, 6,19 35:4,7,10,11, | 15,24,25 36:3 40:23 41:4,7 48:15,22 49:17 50:9,12,13,14, 16,18,21,23 51:2,5, 6,13 52:5,10 54:4, 20,22 55:4,9,10,15, 18,20 56:2,5,11,16, 20 57:2,10,12,14 58:2,10,14,17 59:1, 21 64:14,15 65:4,6, 8,21 66:12,16,20,23, 25 67:6,23 68:2,8, 13,14,17,21,25 69:3 74:19,20 76:3,12,18, 24,25 77:5,9,10,11 81:4,13,25 82:4,8,16 84:21 88:2,24 97:15, 19,22 98:17 100:9 102:1 106:7 107:13 110:25 111:3,4,9,22 112:10,15,16,25 113:12 114:11,12,13 120:15 122:14,16,17, 19 123:14,25 125:13, 23 126:11,18,19 129:8 138:7,8,9,19, 22,23 139:2 140:12 143:18 149:12 150:15 151:8,13,19,21 152:4,7 154:16 159:3 160:15,23,24 164:1, 2,4,6 167:10 171:15 172:8,18,19 173:12 186:15 coding 111:16 112:21 113:3,19 149:7 158:14 164:3 cold 7:21 collateral 38:16,18 collected 105:20 College 13:11,16 Columbia 14:20 combination 64:7 70:7 76:8,20 79:10 112:1, 2 157:1 combined 72:15 164:12 commencing 5:2 comments 108:16 109:14 119:20 125:18 160:7 178:14 187:20 Committee 35:2 common 25:24 87:19 | 91:5 104:16 106:25 107:2 161:13 164:2,3 171:12 communicate 10:7 56:21 68:25 70:22 72:1 75:1 100:1 124:7,15 163:21 communicated 24:9 124:6 151:4 163:19, 22 communicates 155:5 160:23 communication 47:2 60:6 61:15 64:12 65:11 71:1 79:25 80:12 112:11 133:2 146:13 151:10,24 152:3 154:23 155:12 156:6 167:6 communications 8:20, 21 44:22 45:4,9 47:1,13 54:2 109:8 154:14 155:25 community 180:21 companies 30:18 51:22 105:4 company 29:13 30:15 34:24 45:10 61:7 96:8,14 100:18 108:22 112:18,20 113:2 176:13,15 comparable 77:15 compare 114:16 compared 51:10,11 comparison 18:5 52:3 comparisons 77:15 compendia 41:16 compendium 112:25 complaint 96:12 complaints 105:6 completed 53:6 180:14 complex 89:1,2 103:19 complicated 89:8 component 47:7 112:5 180:23 comprehensive 51:8 52:9 concept 163:16 concern 94:16,20 112:9,10 127:8 |
|---|---|--|

| | | |
|---|--|--|
| <p>concerned 30:20 181:22</p> <p>concerns 96:22</p> <p>concluded 188:20</p> <p>conclusion 178:3 186:8</p> <p>conclusions 178:2</p> <p>Condry 5:9 142:5,8, 15,20,21 143:9 145:21</p> <p>Condry's 145:17 146:20</p> <p>conduct 46:1</p> <p>conducted 44:20 46:13 47:12 52:12 128:7</p> <p>conference 10:11</p> <p>confidential 32:22</p> <p>confidentiality 12:3 46:11</p> <p>confirms 123:24 125:7</p> <p>Congress 34:16</p> <p>conjunction 23:2,14 72:14 123:4 184:4</p> <p>considerable 15:24 180:22</p> <p>considerably 89:1,2,7</p> <p>consideration 104:23</p> <p>considerations 111:21</p> <p>considered 61:12 173:5,9 181:15</p> <p>consistency 18:3</p> <p>consists 8:23</p> <p>consultant 14:11 15:18,20,25 19:22 22:11 27:21 34:4 180:10</p> <p>consulted 14:14</p> <p>consulting 11:20 15:23 16:9,18 17:13 25:1 30:8 32:5,7 34:10 100:15</p> <p>consumer 108:22 153:11</p> <p>consumers 112:9 152:17</p> <p>contact 61:21,23 64:18,19,20 65:1 73:15,19,22 82:14 85:13 86:1 89:19 92:5 98:22 99:19 100:16,19 103:20,25</p> | <p>104:9 109:2,25 110:16 118:8,12,13, 15,24 153:10 156:18 157:8,16,20 158:6,12</p> <p>contacted 139:5,9 140:12</p> <p>contacting 100:17 108:20 109:24 119:22 167:8</p> <p>contacts 99:15 107:12</p> <p>contained 91:7 174:21 186:16</p> <p>content 101:2 186:4, 15</p> <p>context 33:11 35:12 46:4 53:14 54:17 64:8 74:4,11 75:15 122:21 123:12 153:2 155:8</p> <p>continue 143:14</p> <p>continuous 22:22 23:7</p> <p>contract 101:16 177:23,25</p> <p>contracts 101:12,19, 23 105:4 177:12</p> <p>convenience 8:3</p> <p>conversation 95:21 140:7</p> <p>copies 33:2 108:19 109:22 110:8</p> <p>copy 32:24 130:12,23, 25 131:21 132:13 141:4,7 182:15</p> <p>core 76:8,19,22 111:25 112:2,5 124:2 125:8,12,22 126:9,21 129:22 131:6 136:8 139:15,19 142:15,24 143:22,25 144:18,19 145:1,21 148:21 149:19 150:8,10 151:1,14,16</p> <p>corner 80:4,19 108:4</p> <p>Corporation 22:18 26:18</p> <p>correct 10:21 11:6,7, 19 13:7,8 14:24 19:1 27:20 53:8,18,19 59:5,7 65:21 72:11, 19 74:1 75:24 88:24 90:6,12 92:2,3,14 98:10 101:4 103:3,4,</p> | <p>10 115:23,24 127:18 135:14,15 137:7 144:21,23 147:9 153:8 155:9,15,22 156:3,10,13 161:23 167:17 170:15,16 174:5 177:14 185:2 186:20,21</p> <p>corrected 167:16 168:2</p> <p>correctly 27:9 49:23 63:19 172:6</p> <p>correlates 162:8</p> <p>cost 31:9 173:25 177:4</p> <p>cost-sharing 173:21</p> <p>Costa 5:16</p> <p>counsel 5:18 10:13 42:8 173:15 180:5,6 182:14 183:13</p> <p>counsel's 182:16</p> <p>count 28:7 71:23</p> <p>counted 71:24</p> <p>country 29:14 34:21</p> <p>County 14:18</p> <p>couple 9:11 51:6 58:24 80:18 181:6</p> <p>courses 13:23</p> <p>court 6:2,21,22 7:7 31:1 36:23,25 37:15, 16</p> <p>court's 48:18,21 156:21 173:12</p> <p>cover 98:17 128:10 162:21 185:9</p> <p>coverage 21:4 31:8 34:10 173:8 177:7 187:6</p> <p>covered 48:10 71:15 88:20 127:17 140:10 148:15 178:9</p> <p>covers 70:13 98:17</p> <p>CPT 64:4,14,23 65:4,8 66:19 67:3 79:8 143:18 150:14 156:24 157:13 161:14,15,16, 18,19,21 162:3,4 164:1,4 166:19</p> <p>CPT/HCPs 166:14</p> <p>CR 5:5</p> |
|---|--|--|

| | | |
|---|---|---|
| <p>CRAC 120:14 CRC 121:13 create 77:2,3 created 37:18 96:7 180:19 181:11,16 187:13 188:3 creating 99:25 111:22 critical 155:21 Cross 12:14,16,19 22:6,7,8,9,16,20 36:20,22 37:25 38:1 47:17 51:7,13,20,24 60:23 CSR 5:4 current 27:24 customary 48:4,12 customer 89:6 104:20 165:1,17 178:6 customers 30:10 cut 44:3 CV 13:5 14:23 15:5 19:4 20:5,21 25:16 26:15 34:15 37:5</p> <hr/> <p style="text-align: center;">D</p> <hr/> <p>Dakota 29:25 Dalton 30:4 damages 38:18 Danielle 39:6 data 40:3,4 54:24 110:18 112:7 172:22 173:3 date 39:9 148:14 184:2 dated 78:9 dates 184:8 daughter 147:21 Davita 18:15 day 185:25 days 130:19 134:5 184:11,19,21 deal 109:1 157:17 dealing 20:12 30:9 66:1 91:4 171:2 dealt 48:6 Dear 132:1 141:6 Deborah 29:24 December 12:23 39:17 78:9 130:5 183:25</p> | <p>184:20 decide 90:18,19 decided 38:20 decision 52:24 85:13 108:16 109:13 127:24 160:7 178:14 187:19 decisions 61:13 173:6 declaration 77:8 99:12 107:11 109:9 110:17 171:18 174:3 declarations 40:25 53:20,21 54:1 77:7 declared 35:18 deductible 176:22 deductibles 125:8 177:17 Deegan 5:22 8:12,19 9:15,24 11:1 12:1 48:24 71:4 72:25 83:2 84:14 86:25 88:15 91:16 92:19 93:8 94:24 97:2 102:20 104:4,14 105:22 106:3,8,15 107:23 117:15 130:22 134:12 137:8,19 141:24 143:1,14 144:2 152:19 153:1 158:15 165:2,11,19 166:5 168:16 174:23 175:8 177:10,18 179:15 180:2 184:22 188:9,13 deem 109:19 defendant 38:17 defendants 5:23 9:22 17:20,21,22,23 18:2, 4 21:7 179:10 defense 42:7 173:15 define 54:21 71:16 152:20 definition 166:20 degree 13:12 degrees 13:25 demands 31:15 demonstrating 83:25 den- 148:14 denial 53:17 54:3 58:15 59:8,12,14,15, 19 65:2 70:22 71:13 72:2 73:14,15 74:21</p> | <p>75:1 84:13 98:22,24 100:18,24 101:7 104:10,24 118:7 124:9,16,17,21 125:22 126:18 127:16,20 129:2,23 131:7,9,10 136:8,13, 23 139:15 142:15,24 143:16,25 144:18,19 145:1,21 147:15 148:5 149:19 150:9, 10 151:1,14,16 152:6 154:20 156:19,20,21 172:24 denials 62:2,9 67:10 69:1 71:23 88:13 99:10 104:1 105:7,9 110:16 117:14 124:2 125:12 126:2,9,22 162:18 denied 27:10 61:22 69:17,19 70:9,12,18 71:3,8,12,14,22 79:16 91:13 100:8 119:3 120:8 127:15 128:20 130:7 134:9 137:3 139:11 144:12 146:10 147:3,5,11 148:18,21 149:4 151:23 184:20 186:24 denominator 105:19 deny 56:11 58:11,13 134:6 denying 56:6,17 104:13 105:10 department 71:7 81:16 82:2 106:6 181:11 depend 114:4 dependent 28:19 depending 33:2 95:14 143:13 177:2 depends 63:8 74:9 84:16 168:5,6 177:23 deposed 126:24 deposition 5:1,8,10 8:10 9:9 10:4,14,17 12:23 20:5,16 36:24 37:9 39:11 42:13,17 43:18 77:22 78:1 110:17 123:21 125:19 134:15,22,23 135:10 141:24 142:4,8,13</p> |
|---|---|---|

| | | |
|--|--|---|
| <p>143:6 145:8,12,17, 18,25 146:20 149:25 157:10 188:20 depositions 6:16 40:25 43:15,19,21,24 125:15 126:13 159:1, 5,6 depth 43:22 derive 28:12,14 derives 28:15 describe 112:17 151:9 describes 47:10 77:8 79:9 94:8 98:16 143:18 156:25 describing 22:24 57:1 86:9 164:17 description 48:12 64:9,10,11 66:10,19, 20 121:24 124:20,22 151:24 164:16 167:2 descriptions 47:5 49:13,15 67:13 77:14 113:6,7,19 123:24 design 34:11 68:17,20 86:4 97:7 110:25 111:4 designated 183:9 designed 55:5 67:23 82:11 85:24 89:16 desire 58:20 detail 49:7 79:2 details 158:20 determination 55:7 82:17 85:11 86:14 117:10 130:4 153:7 164:24 165:16 166:3 176:25 determinations 178:25 determine 7:1 24:10 77:14 126:1 determined 24:12 48:5 60:7 154:1 determines 59:16 developed 31:17,23 32:1 76:25 181:17 development 111:15 180:16 181:25 develops 77:9 devoted 16:2 112:4 diagnoses 138:1 162:6</p> | <p>diagnosis 100:9 138:7,12 161:19,22 162:1,3,5 169:18,22 diagnostic 82:16 dialogue 55:6 70:23 72:12,14,16,20,21,24 73:4,8 85:12 86:5, 12,19,22 124:16 141:17 146:5 185:16 186:9,11 188:3 dialysis 18:16 diary 180:17,19,23,24 dictated 56:16 dictates 82:7 difference 45:18 115:15,17,20,22 116:4 117:12 121:2,7 differences 24:21 74:12 116:11 differently 73:10 173:9,10 difficult 7:1 23:19 35:16 48:22 49:4 62:22 63:24 163:14 165:21 176:4 digit 169:19 digits 169:22 diminish 34:20 direct 14:13 26:1 44:18 63:10 103:25 106:24 119:24 124:24 131:25 134:24 136:15 137:13 157:19 178:23 directed 43:22 118:7 160:10 directing 178:18 direction 75:22,23 107:14 158:12 180:22 directions 181:20 directly 16:6 28:21, 23 58:15 61:15 73:16 107:3 113:5 160:12 director 15:6,11 16:7,9 directors 15:10 directs 107:15 109:2 178:21 disagree 85:12 disagreeing 49:2 discipline 13:20</p> | <p>discount 78:18 discourage 153:3,12 discrepancy 162:15 discuss 33:20 53:16 138:22,23 179:6 discussed 54:23 56:5 111:2 145:24 165:4,5 183:12 discussing 79:18 171:14 discussion 124:13 125:15 128:18 139:1 143:20 155:6 discussions 57:22 95:6,11 disposition 78:25 dispute 48:21 disputing 30:14 distinguish 123:18 distinguishing 42:1 distributed 21:12 180:20 doctor 132:9 141:10 180:25 doctor's 14:10 document 46:21 82:6 96:12 110:13 135:19 143:2,4 182:8 185:19 186:19 documentation 8:25 40:24 94:5,7,8,10,12 96:5,7,14 122:6 documents 8:11 41:24, 25 42:6,7,22,23,24 43:11 45:4,5,16 47:9 53:13 96:16 108:16 109:14 119:21 126:25 160:8 178:14 187:20 dollars 105:18 Doug 8:16 draft 44:9 drafts 44:8,11,14 draw 182:9 185:13 drawing 45:15 77:17 drive 152:25 duly 6:6 duties 14:25 DVD 145:6</p> |
|--|--|---|

| E | | |
|--|---|--|
| earlier 26:23 47:16 85:22 111:1 113:21 119:13 155:1 177:16 178:9 179:6 182:8 183:12 | employers 105:3 | 5 156:3 159:11 160:3,12,14 178:10 179:2 183:9 184:25 185:16 186:4,8,13,16 188:4 |
| Early 180:6 | encompassed 164:10 | EOBS 23:25 47:3,5,6 48:16 52:9 58:22 67:11 68:12 69:3 74:6,8,12 75:23 84:18 88:1,23 90:2 91:23,25 102:1 103:22,24 117:13 152:17 153:3,16 159:18 171:23 178:10 186:18 |
| easier 18:22 103:10 | encourage 152:17,21 153:3,12 181:7 | ERISA 29:20,25 30:6, 7,10,17,20,22,25 31:3 44:21 45:3,5,7, 8,10,13,21 46:6,21 67:9,16 108:11 153:9 |
| easily 67:23 68:3 75:18 79:14 94:14 111:22 113:25 114:7 | end 59:15 95:14,18 184:18 | ERISA-RELATED 29:19 |
| East 5:3,11 | Endicott 92:1 129:18, 20,21,22,25 130:5 131:8,22 132:1,15 133:4,14 134:14,23, 25 136:8 141:6,16,24 157:11 162:22 168:24 169:11,21 170:9 182:5,25 183:9 184:6,15,25 | error 116:24 |
| easy 18:5 33:17 49:21 63:7 | Endicott's 135:10 | establish 185:15 |
| economics 13:6,24 | endorsed 37:15 | established 30:16 51:3 76:4,19 177:16 180:24 |
| educated 65:17 | ends 42:12 77:21 145:7 | estimate 17:24 |
| education 36:7 | English 68:11 | evaluate 22:2 |
| educational 13:5 | enrolled 81:7 | evaluated 22:2 |
| effect 63:10 138:20, 24 | enter 81:8 | evaluation 21:22 |
| effective 80:12 133:2,3 152:4 167:6 | entered 83:17 143:2,5 | evaluations 17:17 |
| effectively 124:6,15 153:17 | entire 11:3 23:22 43:18,24 72:19 | event 116:3 |
| efficient 102:9 103:15 | entirety 72:15 | eventually 37:4 |
| effort 61:7 68:9,13 76:23 88:8 113:15, 20,21 | entities 15:25 30:17 76:5 | exact 113:12 |
| efforts 181:7 | entitled 102:17,22,24 | exam 14:6 |
| electronic 57:6 112:7 | entity 181:16 | examination 6:10 53:12 180:1 |
| element 35:25 36:3 38:17 84:20 | enumerator 105:17 | examine 23:24 50:10, 16,21 52:5 |
| elements 17:17 47:18 | environment 61:5 | examined 6:7 50:22 177:24 179:1,9 |
| eligibility 186:1 | EOB 41:12 47:13,24 57:20,23 58:5 59:5, 7,23 60:12 64:8 66:5 69:24,25 70:14,17,25 72:15,19,23 73:25 74:5 79:1 80:13 82:11 83:14,17,24,25 84:10,20,24 85:3,8, 10,17,24 86:4,6,10, 13,14,18 87:14,16 89:16,25 90:5 91:11, 12 92:4,8 93:13,19, 21,24 94:11 96:20 97:7,13 103:20 107:14,19 108:8 109:3 114:17 115:2 125:4 128:4,8,25 129:24,25 130:4 131:14 142:20,21 143:6,9 146:9 153:4, | excerpt 150:1 |
| eligible 186:3 | | excerpts 134:22 |
| eliminate 57:15 154:16 | | exchanges 34:12 |
| Ellen's 149:13 | | exclude 38:24 107:18 |
| Em-hmm 28:2 52:18 87:21,25 114:21 121:1 129:19 | | excluded 36:13,24 38:10,14 39:1,3,5 |
| employee 14:13 30:5, 14 100:15 109:6 | | exhibit 12:23,25 78:4,5,7 85:16,17,19 87:3 92:8 96:20 101:2 107:23 127:5 |
| employees 22:12 45:10 105:6 | | |
| employees' 30:16 | | |
| employer 88:20 | | |

| | | |
|--|--|---|
| <p>129:25 130:2 134:4, 20 135:10,20 141:3, 23 143:3,5 149:23 168:11,13 169:5 182:3,4 183:9 184:5, 13,17,24 187:17 188:5 exhibits 83:1,7 108:1 123:22 129:14 exist 58:19,20 existing 21:23 expanded 40:15 Expanding 18:19 expect 41:11 67:2 124:23 130:15 152:7 156:17 157:7 expectation 158:11 170:2 expected 124:1,4 164:8 expecting 152:6 expects 103:6 expedited 188:15 expended 105:18 expenses 20:12 21:2,3 experience 35:13,19, 22 36:6,9 53:7 61:17,25 62:12 65:25 66:7 76:2 77:2 85:22 89:9 91:3,5 92:23 94:3 95:6 97:11 98:19 99:4,8,22 101:19 104:17,22 107:10 111:5,7,25 119:14 161:12 171:2 173:18,20 174:8,10 175:15 180:7 186:22 187:1,16 experiences 123:23 experiencing 138:4 expert 11:17 12:24 15:18,23 17:6,19 18:10 19:17 20:10 21:14 26:3,10 30:22 31:1,3,11,14,18,20 33:13 34:13 35:14, 20,22 36:2,4,6,11 39:24 52:16 106:25 179:9 expertise 31:6,24,25 experts 35:17</p> | <p>explain 69:5 78:12 79:15 102:6 124:19 161:24 explained 47:22,23 explains 78:14 explanation 23:25 48:15 57:23 59:11 78:8,16 84:12 94:13, 19 explanations 41:1 56:25 58:18 explicitly 178:22 expressed 52:22 179:4 extended 39:21 extension 164:4 extensive 53:7 extent 25:8 143:1</p> <hr/> <p style="text-align: center;">F</p> <hr/> <p>facility 14:9 132:9 141:10 fact 37:2 60:24 61:18 63:9,23 65:12 66:3 76:21 96:4 109:3 121:19 146:9 150:6 151:12 152:24 156:3, 12 158:8 165:24 176:6 factor 29:5 factors 29:1,3 48:6 fails 134:1 170:13 fair 7:17 81:11 102:17 110:12 165:8 fairly 15:14 20:14 23:8 38:8 51:7 52:9 53:24 familiar 71:7,9,11 95:2 105:13 familiarized 182:7 family 66:4,14 108:15 160:6 178:13 187:18 FB000015 127:8 federal 180:14 fee 47:18 feel 35:18 40:9 91:14 102:24 152:15,17 153:7 feeling 104:16 feels 106:13</p> | <p>Felicity 92:1 127:7 129:7 152:11 fell 51:24 felt 147:9 fewer 58:18 field 35:22 36:7 101:25 file 8:11,23 9:3,6 108:12 129:10 152:17 153:9 166:9 187:25 filed 12:15 127:22 filing 96:13 152:25 final 44:9 85:11 86:14 finalized 44:16 Finally 135:16 finance 31:7 35:2 financial 104:18,19 105:8 find 30:4 34:5 41:22 80:14 83:16 87:13 96:2 113:11 115:15 124:23,24,25 128:7, 8,19 129:24 142:17, 20 148:16 157:16 183:10,14 finding 48:21 49:3 findings 25:3 fine 9:23,24 34:21 106:15 finish 7:10 44:13 finished 7:12 Finkelman 5:25 firm 11:6 16:7 Florida 22:7,8,21 focus 10:16 47:8 50:14 focused 24:7 50:11 51:21 112:5,6,11 follow 51:1 176:5 follow-up 179:14 footnote 51:16 82:20, 22 83:2,3,12,23 89:12,14 142:7,10 forgive 152:16 forgot 39:11 form 48:24 71:4 72:25 80:20 84:14 88:15 91:16 92:16,19 93:8 94:24 97:2 102:20 104:4,14 105:22</p> |
|--|--|---|

| | | |
|--|--|---|
| 106:3 117:15 134:12 137:8 138:1 144:2 152:19 158:15 165:2, 19 166:14 174:23 188:6 formal 44:14 formally 166:9 format 47:24 74:16 93:2 formed 17:4 forms 41:12 Forty-six 20:6 forward 67:6 found 38:21 41:9 48:16 51:6 140:17 foundation 71:1 founded 16:10 founding 17:5 fourth 30:3 169:19,22 fraud 96:21,23 free 108:19 frequently 47:25 56:24 65:12 66:4 71:14 88:9,14 123:17 friends 66:4,14 front 130:24 168:15 184:4 full 38:4 50:13 68:23 69:18,20 70:9 163:1 171:17 function 124:12 functioned 124:1,4 125:23 functions 124:11 future 20:12 21:1 | Georgia 18:18 38:12, 22 39:4 give 11:4 40:10 59:24 69:9 80:2 115:13 118:3 156:13 good 5:7 6:12,13 29:4,5 70:11 104:22 106:12 109:1 162:2 Google 41:8 52:12,13 83:19 governed 108:11 government 16:1 102:12 180:14 great 52:13 92:24 Greatbanc 30:6 greater 104:19 ground 6:17 group 5:10,23 15:7 16:6,25 17:3,4,5 22:12 28:15,17,20 29:8 34:14 76:15,23 97:9,12 Growth 39:7 guess 47:22 66:2 85:17 111:11,12 112:15 130:14 155:24 157:11 184:23 186:18 guy 29:4 guys 188:16 | 21:21,22 22:11,13,14 24:18 26:24 27:15 30:9,19 31:8,9 34:9, 11 36:1 45:3,11 46:7,8,17,20,23 50:6 53:7 54:19 58:10 60:17 61:25 66:6 69:4 71:2 72:16 76:2,11,13 81:17 82:3,14 85:23 86:2 88:19,20,21 89:19 90:11 92:24 93:1 94:4 99:9 100:18 101:13,16,21 104:12, 17,23 105:4 107:3,10 109:2 110:24 113:10 153:11 160:16 161:6 162:10,12 171:2 174:9,11 175:9,14 177:7,13 180:15,21 181:4,5,11 187:4,9 healthcare 9:8,12,19, 22 10:8,13 15:14,15 18:21 19:6,7,22 22:17 23:4 24:25 31:7,9 53:17,18 54:3,17 55:21 56:1, 4,9,15 60:20 62:7, 11,18 65:1,14 66:8 68:16,19 74:11 76:14,18 83:17 89:25 90:15,16,25 92:5 93:7 97:6 98:20 99:2,5 101:6,24 103:5,6,24 106:2 109:6 111:19 112:4, 12,23 113:25 116:5,6 118:2,6,8,11 120:6, 23 121:11,16 122:3 129:9 132:9 141:10, 18 146:4 150:7 151:19 153:16 154:24 155:25 156:8 157:19 159:24 161:3 162:17 164:2,3,23 166:3 170:6,14 171:3 173:23 175:11 176:12 178:18,20 180:10 186:22 187:1 Healthcare's 10:23 11:5 174:22 175:12 177:24 hear 7:20,22 |
| <hr/> <p style="text-align: center;">G</p> <hr/> Gaddy 38:22 Gallagher 5:11 gave 25:11 37:19 42:4 general 14:18 15:4 31:7 39:7 40:9 81:6 90:2 110:10 175:9 generalized 42:2 generally 31:15 40:2, 10 54:13 59:22 67:10 73:25 159:12 173:23 175:3 | <hr/> <p style="text-align: center;">H</p> <hr/> half 20:22 halfway 185:19 hand 158:10 handle 90:15,25 handled 162:15 Hanson 8:16 happen 20:1 45:25 94:21 118:10 161:24 happened 36:16 hard 31:13 47:15 63:20 163:16 HCPCS 64:4,15,23 65:4,8 66:19 67:3 79:8 150:14 156:24 157:13 164:2 166:19 head 116:2 health 11:23 15:6,16 16:1,11,15 17:9,12 18:3,6,25 19:3,8,9 | |

| | | |
|--|--|--|
| <p>heard 65:8 heart 162:1 height 181:1 held 42:15 77:24 145:10 179:20 Helen 5:4 6:2 helps 119:21 185:15 Henry 5:1,8,21 6:5 42:13,17 77:22 78:1 145:8,12 Hewitt 8:16 high 172:7,19 higher 38:5 highly 59:19,20 61:21 Hipple 150:1 152:1 Hipple's 157:10 hmm 115:11 hold 13:25 14:4 133:12 honestly 144:9 148:7 Hopkins 14:21 Horizon 22:9 hospital 14:10,12,14, 16,18 15:1,2,4 26:18 36:19 37:23 38:2,3 hospitals 16:1 71:19 hour 8:2 42:11 hours 8:18 39:22 41:13,15 42:4 Howard 14:18 Hoy 69:10 72:1,6 78:9 80:10,13 90:4,7 91:25 92:9 100:5 108:1 114:16 152:11 Hoy's 78:13 huh-uh 7:1 Hundreds 55:19,22</p> <hr/> <p style="text-align: center;">I</p> <hr/> <p>I.D. 186:2 I3 128:8 I5 55:14 69:9 72:22 114:15,19 116:15,20 ICD-10 138:16,19,23 ICD-9 138:14,22 169:18,22 idea 71:5 150:25 151:22</p> | <p>identical 123:17 identification 12:25 78:5 81:9 83:8 87:3 127:5 129:15 134:20 141:23 149:23 168:11 identified 49:17 55:11,12 103:23 128:17 156:21 162:25 identifies 57:24 79:25 80:22 99:13 107:12 108:10 110:18 124:20 161:16 176:11 identify 5:19 19:15 41:3,11 51:22 84:18 111:8 129:7 162:14 165:24 identifying 76:24 126:22 128:17 157:15 imagine 81:19 94:18 102:25 immediately 22:19 73:3 92:7 125:17 146:9 impact 34:24 impetus 170:6 implementing 93:6 implication 162:21 implications 30:1 implied 157:10 implies 101:2 120:3 128:18 imply 125:19 importance 181:23 important 7:9 47:7,25 50:25 60:1 70:12 74:1 91:19 117:1 177:6 181:21 importantly 49:12 in-network 45:19 101:15 177:13,25 inadequacy 172:23 183:4 inappropriate 62:21, 23 79:11 144:20 148:25 150:11,20 151:5,17,25 152:8 153:25 155:3 157:2 158:19 160:18 include 45:17 51:19 62:4 68:6 71:20 76:14 99:15 159:20</p> | <p>179:8 included 23:25 50:12 55:1 71:14 113:6 124:22 166:14 175:1 176:6 180:22 186:19 187:7 includes 8:24 53:12 61:14 67:9 80:21 97:19 110:1 175:19 176:13 including 17:9 31:10 58:3 76:3 82:15 85:23 111:19 112:8 154:12 169:18,22 181:6 186:12 inclusion 116:25 income 28:12,15,16, 19,20 180:20 incomplete 120:18 121:9,10,15,20 inconsistent 116:9 Incorporated 5:10 incorrect 100:9 154:20 168:1 increased 156:11 independent 64:1 112:20 122:23 indicating 130:13 162:22 indication 69:25 70:11 72:4 78:22 86:11 92:10 93:18 134:4 159:9 170:22 184:10,18 individual 18:9,11 57:15 60:3,7,10 66:23 81:15 90:18 117:9 123:23 164:14 168:6 187:8,22 188:3 individual's 81:15 individualized 58:8 61:11 73:2 80:11 93:1 94:16 155:23 individually 83:11 162:16 187:12,14 individuals 16:20 industries 111:18 112:23 industry 49:14,15,21, 25 50:7 54:7,10,12, 14,15,17,18,19,21 65:14 68:14 76:7</p> |
|--|--|--|

| | | |
|--|---|--|
| 77:6 94:4 111:14,19 112:24 113:2,4,5,9 176:12 180:10 186:23 187:2 industry-standard 123:25 infant 181:22 infants 180:17,19 informally 166:8 information 12:3 23:24 25:7 45:17 48:7 55:5 56:22 58:3,16,21 59:2,5,8, 18,19,24,25 60:5,12, 25 61:3,18,20 69:1,2 74:2,4,16,18,20,23, 24 80:2,8,23 81:3,9, 13,15,18,24 82:12,15 83:18,24 84:2,25 85:24 86:2 87:13,17 88:7,10,23 89:11,16, 20,23,24 90:7,10,14, 20,24 91:6,11,14,15 92:5,15,23 95:15 96:2 97:14,17,21 98:1,5,23 99:11 100:23 101:6 104:9 106:1 107:4,19 108:8,17,19,22,24 109:1,14,18,21,22,25 110:8 111:16,17 112:21 113:22 119:3, 10 120:2,3,10,14,16, 22,24 121:8,14,17,20 122:4 124:22 128:16 130:8,13,17 131:11, 16,19 132:17,19,21, 23 133:6,7,9,10,13, 15,16,17,18 134:6 135:19,21,23 136:1, 11,14 137:3 139:4, 18,20,23 140:1,3,21 152:24 155:15 156:4, 13 160:1,8 161:14 165:24 167:17,21 169:1,11,13,18,25 170:11,14,21,22 171:13,14 172:4,17 173:4 174:21 175:4, 17,22 176:2,5 178:15 179:1 183:2,5,6,21 184:6 185:15 186:4, 13 187:7,21 | informed 130:18 141:8 164:23 165:15 informing 130:19 139:7 initially 23:8 37:16 52:9 71:12 initiate 55:6 65:11 70:23 72:15,24 73:7 86:4,22 124:16 146:5 185:15 186:9,10,19 initiated 186:23 initiates 72:13,20 141:17 initiating 72:12 initiation 73:8 86:18,21 injury 20:10,11,22,24 25:20,22 27:25 28:9 33:11 34:7,8 37:21 38:13,17 Innis 29:24 30:12 innovative 181:6 inquire 152:13 inquiries 57:15 58:19 62:2,9 82:8 99:13,15 inquiry 58:8 insinuates 73:20 instance 25:11 34:19 45:17 60:11 71:18 88:19 98:12 109:12 instances 24:12 36:14 46:15 47:15 58:14 60:4,18 71:20 75:7, 10 84:23 99:11 101:14 111:8 122:24 164:16 171:11,12 180:13 Institute 111:13 instruct 170:9 instruction 93:17 119:4 instructions 99:23 146:11 insufficient 120:18 121:9,11,14,20 insurance 11:23 15:16 26:19 30:19 31:8,10 34:9,12,24 45:11 46:18,20 50:6 53:7 61:7 66:6 88:19,21 94:4 96:7,13,21,23 | 100:18 103:2,12,14, 16,18 105:4 108:21 113:17 136:21,25 137:5 161:6 176:13, 15 177:1 insured 35:10 56:23 57:22 58:21 60:3,7, 12,13,15 61:9,11,12, 15,23 62:22 63:7,20 64:3,6,12 66:15 67:12 72:7,16,24 73:13 74:2,13 75:2, 19,21 79:15 80:2 86:5,19 94:6,10,14 119:21 124:14,24 insured's 61:14 63:19 175:25 insureds 41:7 44:23 47:2,3,13,23 56:21 59:2 60:19 67:24 68:3 73:3,6 95:7 102:1 insureds' 62:2,8 insurer 46:23 48:5 57:8 59:16 60:7 72:24 73:19,23 74:9 76:24 86:5 95:2,19, 23 96:5 102:10,12, 14,18 103:10 113:10 119:7 159:25 161:10 174:16 176:10 177:2 insurer's 58:20 153:12 insurers 30:9 34:11 36:1 41:4,12 45:3 47:19 50:1,17 51:1, 23 52:4,6 54:23 55:2,18 56:19 57:11 58:10 59:1 60:17 62:13 68:12 71:3 76:21 77:3 86:19 89:10 91:1,4 92:25 93:1 95:7 105:21 112:7 113:16,18,19 154:15,19 162:11,13, 18 171:3 174:11 insurers' 50:9,21 intelligence 65:19 intended 64:22 68:3 70:2,3,25 81:6 84:12 86:18 88:11 113:4 152:4 186:10 |
|--|---|--|

| | | |
|---|--|---|
| <p>intending 52:19 115:20 124:7 intense 147:25 intent 24:8 68:1,5,20 119:23,25 120:1 intents 119:25 Interact 15:2 interaction 161:9 interest 41:4 99:14 101:10 102:4,7,16 103:16 104:12,20 105:8,10 interested 17:2 18:24 interesting 37:14 38:8,21 40:19 interests 104:18 105:9 internal 34:13 International 29:15 internet 40:22 41:9, 14 42:2 43:7,8 52:9 interpret 68:13 182:23,24 interpretation 33:11 95:21 interpreted 47:9 137:7 interpreting 45:3 155:18 intraoperability 112:6 introducing 103:18 investigate 56:8 investigation 128:7 investigations 43:9 111:15 173:6 invite 167:20 invites 167:15 invoice 149:14 invoiced 39:8 involved 19:3,15 20:9,13 26:20 60:19, 23 61:1 119:5 149:15 159:24 160:23 161:2 involvement 20:13,14 involving 11:24 18:6 33:4 Ishmael 38:13 39:5,7 issuance 53:2</p> | <p>issue 10:1 23:1,13 34:2,23 35:1,11 40:6,7 45:20 46:4 47:14,23 48:22 50:18 55:5,9,10,15 64:17 71:16 79:18,25 80:11 94:9 114:11 133:1 149:5,7 157:15 167:25 issued 24:23 37:1 61:9 issues 15:16 23:11, 17,20 26:21 29:21 30:6,7,18 34:4 38:25 43:9 46:19,20 47:20 49:16 53:7 57:22 105:5 112:4 145:6 146:17 180:8,11 181:21 187:4,5 188:1 issuing 154:20 item 78:19 118:20 128:11 148:15 items 185:14 iterations 44:15</p> <hr/> <p style="text-align: center;">J</p> <hr/> <p>Jackson 30:2 Jance 69:10 72:1 78:8 80:10,13 91:25 92:9 108:1 152:11 January 5:2,13 jargon 136:21,25 137:5 Jersey 22:8 181:10 Johns 14:21 join 16:22,23 Jonathan 5:14 judge 38:14,20,23 49:14 55:11 67:20 judgment 48:19 50:12 55:12 67:20 173:13 justice 37:13</p> <hr/> <p style="text-align: center;">K</p> <hr/> <p>Kennedy 5:11 Kentucky 12:18 34:1,9 key 38:16 86:9 180:23 kidney 18:16</p> | <p>kind 47:24 49:10 73:1 111:11 129:9 148:12 157:3 171:14 kinds 37:18 181:21 KM 55:14 64:10 79:4 108:9 143:17 151:4, 24 160:18 knew 127:20 130:17,20 131:10 133:15,16,17 142:8,15 150:3,6,17 knowing 151:20 knowledge 35:18 40:15,16 60:18 65:15 66:13 67:3 141:13 144:16 knowledgeable 62:11</p> <hr/> <p style="text-align: center;">L</p> <hr/> <p>lab 164:11,12,18 Labor 71:7 lack 61:2 lactation 33:5,8 56:6,10,17 180:8 181:24 Lake 92:12 93:15 language 24:3 50:17 51:2,12,17,20,22 52:5 58:4,5 59:1,13 63:22 64:2 67:5,21 68:6,10 70:13 72:3 73:17,18 79:14,20 113:1,3,11,12,18,22, 23,24 114:1,16,22 115:2,16,25 116:4,5, 6,8,14,16,18,21,22, 23 117:2 120:6,21,23 121:7,12,13,16 129:6 141:15,19 142:18,23 143:12 149:2,9,18 151:3 182:20 large 22:13 37:24 50:3,5 57:7 105:2,3 largest 17:9 18:15 22:14 lasted 8:18 Laundry 19:12 Laura 149:25 150:1 152:1 157:10 law 96:9</p> |
|---|--|---|

| | | |
|---|--|--|
| <p>lawsuit 12:15 layperson 111:23 113:23 114:1 161:5 163:12,17 lead 50:25 73:8 117:24 118:3,13,15 159:10 leadership 77:5 leads 57:9 131:8 learn 40:13 80:15 87:23 88:19 learned 38:15 learning 40:10,17 leave 16:15,17,19,24 65:7,9 LECG 16:8,22,24 led 156:7 left 16:22 114:16 left-hand 185:10 legal 5:15 96:12,16 102:22 legible 130:23 letter 120:9 121:17 122:2,8,10,11 127:2, 7,14,19,21 128:22,24 129:5,6,10 130:12,18 131:17,18 132:8,14, 21 133:5,11,21 134:3,7 135:4,11,12 139:3,6,10 140:22 141:4,7,9,15 148:12 162:21,23 168:24 169:14,15 170:6 182:5 183:1 184:10, 18 letters 47:5 131:5, 12,13 134:15 135:13 140:8,13,16,18,21 141:1 level 81:10 license 14:5,6 life 181:15 light 173:1 182:22 limit 134:4 173:11 176:1,7,16 limitations 46:23 47:21,22 limited 20:14 lines 12:3 17:25 71:20 85:14 134:24 135:1,9 136:15</p> | <p>Lisa 30:4 list 18:23 26:2 29:24 89:12 114:10 listed 19:4 20:4,21 25:15 26:14,16,22 29:23 37:5 42:22 43:5,10,12,14 66:12 82:21 114:20 listing 89:13 lists 13:5 52:10 literally 77:16 litigation 15:24 16:3 17:15 21:18 27:25 28:1,9,13 33:19 35:12 46:4 lives 147:20 locate 186:2 located 5:15 14:19 location 75:16 log-in 87:6 long 8:17 39:16 longer 113:8 looked 23:8 41:18 43:4,13 50:23 51:2, 4,9,25 52:6 74:17 87:9 115:12 182:14 Lori 131:3 135:14 136:2 138:12 140:12, 21 141:14 169:16 182:19 183:1 loss 105:13 lost 157:3 lot 15:21,22 21:22 33:16 37:19 38:4 40:11 43:24 44:13 48:1 58:14 61:14 70:13 73:6 76:23 102:9 107:18 129:5 136:20,24 148:16 175:4 181:17 lots 20:18,19 low 7:20 172:6 180:20 lower 36:24 lunch 106:13,18</p> <hr/> <p style="text-align: center;">M</p> <hr/> <p>made 21:25 25:2 32:5, 18 45:10 52:24 57:6 61:7,13 68:9 95:16 96:6 99:13 107:13</p> | <p>115:7 155:7 174:13 175:24 mail 93:14 110:21 mailing 92:12 93:7 main 105:5 maintain 14:6 32:15 105:1 maintained 32:23 maintaining 81:17 major 76:2 85:22 majority 18:1 make 7:22 24:4 35:19, 22 57:25 68:13 82:10 84:22 85:18 113:6, 16,20,21 117:12,21 148:18 165:21 makes 7:8 31:20 63:7 70:8 117:24 148:24 149:2,9 making 146:15 152:3 managed-care 38:1 management 15:2 managing 15:6,10,11 16:5,7,9 manner 6:20 manually 162:15 map 77:17 mapped 114:12 121:23 mapping 77:10,12 mark 12:22 78:3 82:25 85:5 86:23 129:12 134:18 168:7 marked 12:25 39:17 42:21 78:5 83:7 87:3 90:4 127:5 129:14,18 134:20 141:23 149:23 168:11 169:5,9 182:3,4 Maryland 14:20 master's 13:17 match 122:1 162:5 184:8 matches 130:3 matching 77:17 161:19 material 43:24 115:22 116:12 materials 41:20 168:23 169:4,7 181:17,19 maternal 180:12 181:4</p> |
|---|--|--|

| | | |
|---|--|---|
| <p>matter 5:9 8:23 9:22 10:9,19,24 11:6,19, 20 40:16 52:20 121:21</p> <p>matters 11:9,17,18</p> <p>maximized 41:8</p> <p>maximum 175:25 176:16</p> <p>MBA 13:16,21</p> <p>meaning 14:5 158:4 182:24</p> <p>means 7:2 15:11 56:25 60:9 65:11 66:6 75:7 77:13,16 82:13 86:1 89:18 93:6 150:25 151:10 163:10,13,18, 24 169:23</p> <p>meant 150:24 155:18</p> <p>measure 79:22</p> <p>measurement 31:8</p> <p>measures 181:1</p> <p>measuring 28:3</p> <p>Media 42:12,16 77:21, 25 145:7,11</p> <p>Medicaid 31:10 37:25 38:2 76:6 112:8 181:12</p> <p>medical 11:24 14:7,9, 21 20:12 21:2,3 105:13 165:5 166:4 183:4,6</p> <p>medically 164:25 165:16</p> <p>Medicare 31:10 50:24, 25 51:1 76:6 102:12 112:8</p> <p>meet 49:20 185:20</p> <p>meeting 8:17 10:11 108:24</p> <p>meetings 10:13 15:3 25:3</p> <p>member 28:18 69:4 70:22,23 81:12 85:5 87:13,16 97:14 98:21 107:15 108:15 109:2 117:7 118:6,7,13 119:6,8,24 120:9 121:17 122:17 123:8, 16 130:8,10 134:10, 11 153:6 155:5,7,12, 21 156:4 158:5,6,11, 13 159:10 160:6,10, 14 165:15 166:3,22,</p> | <p>23,24 167:1,7,9 171:13 173:7,24 176:6,17,18 177:3 178:13,18 187:4,19</p> <p>member's 87:16 117:13 154:13,23 172:25 173:7 176:20 178:6,7</p> <p>members 17:5 29:7 37:24,25 45:10 55:6 69:2 82:13 84:1 86:1 88:18 89:18 90:15 97:21 99:19 101:6 103:20 104:8 107:2 110:15,20 122:4 123:11,14 129:10 152:25 156:17 157:7, 19 161:1 164:23 171:22 172:7 178:5, 7,21,23 181:15 187:25</p> <p>mention 121:10 181:9</p> <p>mentioned 10:5 27:14, 16 30:13 43:7 47:16 55:3 107:11 119:18</p> <p>mergers 34:24</p> <p>Mesa 5:16</p> <p>mesh 162:4</p> <p>met 8:12 46:24</p> <p>method 37:15</p> <p>Mexico 26:18</p> <p>middle 87:22 107:1</p> <p>Miller 5:1,9,21,25 6:5,12 12:1 13:2 17:8 26:2 39:17 42:13,17,20,21 77:22 78:1,4,7,12 83:4,5, 6,10 86:24 87:5 90:3 91:7,22 93:13 100:3, 22 106:22 108:3,7 109:11 114:17,19 127:2,7,9,12 128:14 129:13,17,21 131:7, 25 134:19,22 135:1, 11 141:22 142:4 145:8,12,15,17 149:22,25 168:8,14, 18 169:5,10 180:3 184:14,16,17</p> <p>millions 187:10</p> <p>mind 9:18 12:4 22:19 38:16 45:18,25 49:19 60:2,24 121:2 185:23</p> | <p>minds 126:4</p> <p>minute 145:16 183:14</p> <p>minutes 42:11 77:20 159:1 179:16</p> <p>misinterpreting 99:20</p> <p>missing 69:2 130:13 131:16 139:4,7,17,20 140:22 184:6</p> <p>mistake 115:7,11</p> <p>Misty 30:4</p> <p>mixing 112:16</p> <p>mixture 27:2</p> <p>modifier 64:7 79:10 157:1</p> <p>modifiers 64:15 65:8</p> <p>moment 182:9</p> <p>money 175:18,20</p> <p>morning 5:7 6:12,13</p> <p>motion 38:23 48:18 173:12</p> <p>Mountain 19:6</p> <p>mouth 126:6</p> <p>move 67:6</p> <p>multiple 57:21 153:8</p> <p>myuhc 87:5 164:25</p> <p>myuhc.com 81:1,12,18 97:20 125:3</p> <hr/> <p style="text-align: center;">N</p> <hr/> <p>names 12:6,10</p> <p>narrative 32:10</p> <p>Nathan 5:24</p> <p>national 76:4 111:12, 13</p> <p>nationwide 29:13</p> <p>nature 11:16 34:22 94:15 187:22 188:3</p> <p>Navigant 16:9,18,19, 22 17:1</p> <p>necessarily 10:19 18:2 41:11 50:1 52:11 58:14 59:22 63:2,3,10,11 65:3 72:13 109:24 124:24 126:10 144:21 146:2 155:12 156:14 161:1 167:13 173:10 176:3</p> <p>necessity 165:5 166:4</p> |
|---|--|---|

needed 133:5,7,10
170:23
negotiated 78:19
negotiations 105:3
Net 26:24 27:15
network 45:21 177:12,
22 181:11 186:2
night 185:25
Nina 77:8
non-litigation 21:21
nondenial 59:5
nonmedical 128:10,16
nonpersonal 34:7
nonprofit 111:14
112:3
normal 141:12
notable 24:20
note 34:15 52:11
96:16 98:13 108:9
109:11 130:24 131:1
168:13,14 182:13,23
184:4
noted 20:4
notes 8:25 79:3 92:8,
10 97:3 98:11 107:22
119:18
notice 9:18
noting 52:6
November 130:12 182:5
number 6:16 11:4 19:2
20:24 26:2 30:7,18
37:24 42:22 47:15,19
48:11 50:3,5 55:24
58:1 71:10 80:17,18,
24 81:21,22,25 82:21
84:1,5,6,8 85:8
87:23 96:1,22,25
98:4,7,14 99:11,13
107:9 110:1 111:17
125:4 126:25 148:17
171:22 181:3 185:10
numbers 84:19

O

object 48:24 71:4
72:25 84:14 88:15
91:16 92:19 93:8
94:24 97:2 102:20
104:4,14 105:22
106:3 117:15 134:12

137:8 143:1 144:2
158:15 165:19 174:23
188:6
objection 84:14 106:8
143:14 153:1 165:2,
11 166:5 177:10,18
obtain 171:24 172:11,
15 186:3
obtained 155:15
obtaining 186:12
obvious 68:5 95:12
97:17 117:19,21
124:25 158:1,3
159:22 160:2
occasionally 16:1
occasions 14:12 21:20
34:5 48:6
occurs 59:15 65:12
October 184:9
offer 52:19
offered 26:3 52:23
129:1
office 10:3 14:10
29:16 100:10,14
119:4
offices 29:14
official 13:22
Oftentimes 100:8
Oklahoma 22:11,12,14
23:5 24:18
ombudsmen 108:23
online 55:1 93:22
94:23 95:3,4,8 96:17
108:25 185:20
onset 180:18 181:14
opined 37:1 55:4
opining 143:9
opinion 37:1,14 49:8,
12,24,25 52:19,21
54:6 70:19,21 72:12
115:23 169:9 172:23
173:11 184:5 185:14
186:7

opinions 52:22,23
53:1,5,10 62:19
179:3,7,8

opportunities 17:2
opportunity 80:13
81:8 84:23 86:21
88:18 89:10 98:3

opposed 102:10
opposition 27:1,3
option 93:14 148:4
order 9:9 10:4,13
25:19 42:25 48:18
64:23 67:20 101:15
103:17 104:25 143:7
156:21 163:1 168:4
170:10 173:13 177:7
188:12,14
orders 12:4
organization 16:11,13
51:4 76:7 111:6,10,
14 112:3
organizations 76:5
77:1
out-of-network 45:19
46:5 48:2,3,10
out-of-pocket 175:21,
25 176:16
outcome 27:7 152:11
outcomes 152:13
outline 101:20
overriding 104:21,23
oversight 15:3
overwhelmed 147:20
owe 78:20
owner 28:17
ownership 30:5,14,17

P

p.m. 106:17,20 145:9,
13 179:19,22 188:20
P.O. 92:12 93:15
109:23
packages 47:5
pages 97:24 135:16
142:7 145:16,24,25
148:23
paid 38:2,3 46:5 48:4
59:11,25 60:14,24
61:2,6 69:25 70:1,3,
11,17 71:21 72:5
78:20 91:2 102:8,9,
15,18,25 103:6,17
164:6,22 167:5 168:1
174:19 175:18,20
176:9,17,19
paper 158:10

| | | |
|---|---|---|
| <p>paragraph 17:7 44:19 52:15 67:8 68:24 75:25 90:2 92:9 107:6 108:10 123:20 132:5,22 153:20 157:5 163:1 168:22 170:19 171:17 178:3 paragraphs 73:22,24 109:11 parens 83:23 parenting 127:23 128:1,5,17 parents 37:25 part 13:4 20:11 22:17 23:9 24:1 25:8 30:21 33:21 41:4 46:16 57:11,14 69:18 71:21 85:3 113:15 116:24 122:6,20 124:3 125:6,21 135:3 145:17 150:12 153:9 164:6,20 176:24 participant 48:2 participants 46:6 113:5 participated 111:3 parties 12:11,13 112:11 159:24 161:2, 10 partnership 99:25 parts 101:11 party 120:17 Pasewark 5:4 6:2 passed 14:5 passing 33:18 55:2 password 89:5 past 17:16 pasted 44:3 patient 74:21 80:15 91:13 95:25 99:25 100:23 102:10,19 103:17 120:22 129:4 154:9 159:25 160:1, 21,22 161:17,22 174:14,19 175:18,22 176:14 patient's 154:9 161:19 patient/insured/ responsible 120:17</p> | <p>patients 34:25 90:24 91:3,7,15 100:16,19 103:2,25 129:5 177:20 pay 38:18 59:17 60:8 103:14 118:21 134:9 170:14 176:14 177:2 payer 102:11 payers 44:22 45:2,3 47:2,3,13 112:7 173:20,23 paying 102:18,19 103:10 payment 21:24,25 23:23 45:19 47:19,22 61:17 69:1 104:18 105:18 108:9 112:17 130:6,7 137:2 payments 175:23 penalties 6:21 pending 8:6 12:17 18:17 Pennsylvania 26:23 27:15 34:25 people 8:13,15 17:1 29:16 50:3,5,6 59:13,14 65:3,21 66:1,7,11 67:3 68:15 70:14 81:7 82:7 97:10,12 100:12 117:10 118:25 119:5, 8 124:21 153:13 159:2 161:11 186:23 percent 16:4 172:7,19 percentage 16:2 17:24 27:24 28:1 71:2 91:10 104:8 110:15, 22 172:2,4,5,14,18 perform 23:5 124:10, 13 performed 161:17 performing 41:17 period 25:18 39:21 perjury 6:21 perplexing 148:16 person 65:17,18 73:9 84:23 93:2 95:14,18 97:9 103:7 person's 114:5 187:3 personal 20:10,11,22, 24 25:20,22 27:25</p> | <p>28:9 33:11 34:7 37:21 38:13,17 81:9 128:11 Personal-touch 30:5 personalized 81:7 personally 39:18 perspective 67:12 Ph.d. 5:2,9 6:5 13:6, 9 14:3 42:13 Phoenix 5:3,12 29:16 phone 10:15,18,22 80:24 81:22,25 82:7 84:1,5,8,19 85:8 93:25 95:10,13,14,19 96:1,6,18,19 98:4,7, 14 110:1 178:24 185:10 phrase 98:16 188:16 physician 14:14 108:15 119:20 160:6 164:20 178:13 186:2 187:19 physicians 71:20 pieces 23:24 pile 142:10 PL 127:8 place 5:11,17 21:23 34:12 37:12 60:16 114:24 115:18 116:1, 9 118:20,22 166:15 179:2 places 84:18 plaintiff 18:9,11,21, 25 19:10,13,22 21:5 142:24 183:13 plaintiffs 5:25 17:20,21,22,23 18:4, 6 43:15,21 92:1 123:22 124:1 125:7, 11,21 126:9,21 131:6 159:6 179:10 plaintiffs' 180:4,6 182:14,15 plan 18:21,25 19:9,22 22:11,13,14 23:4 24:18 26:24 30:5,14, 17 38:1 45:4,5,16,22 46:6,7,8,21 47:8 48:11 60:20 61:15 69:4 70:11,17,23 72:16 78:20 81:8 82:14 85:12 86:2</p> |
|---|---|---|

| | | |
|--|--|--|
| <p>89:19 101:17,21 104:12,17,23 107:3 108:11 109:2 110:24 118:22 128:10 153:10 160:16 175:14 177:7 187:4,9 plan's 45:21 plans 16:1 17:9,10,12 18:3,7 19:3 21:21,22 22:6 24:20,25 30:10 45:5,8 48:11 51:7,25 61:25 76:2,11,13 85:23 99:9 101:13 107:10 174:9 177:13 played 126:19 plenty 75:22 pocket 175:18 point 8:20 9:20 10:1 12:2 24:16 29:9 34:16 43:23 49:19 69:19 85:24 99:21 104:22 119:17 121:21 124:6 125:18 126:8 140:19 147:21 163:21 178:7 points 26:5,7 79:2 178:5 policy 16:11,15,21 56:9,15 poorly 43:2 portion 43:25 44:3 85:8 107:12 187:11 portions 43:14,19,22 position 173:3 possibly 68:11 Post-it 182:13 potential 24:24 34:24 potentially 150:19 Powerpoint 32:12,14 practice 14:14 28:13 54:13 91:5 preceded 98:8 precedent 37:18 precise 163:16 167:4 precisely 67:18 184:3 pregnancy 180:18 181:14 pregnant 180:17 181:13 premiums 105:19</p> | <p>preparation 8:14 39:24 42:21 50:10 prepare 8:9 9:9 10:4, 14,19 25:24 28:5 42:25 43:4 prepared 52:17 preparing 10:8,16 39:16 44:10 prescriptions 186:3 present 5:19 presentation 25:11 32:11,12,18 presentations 25:3,6 32:6,8,14,18,21 33:3 presented 32:3,4 74:2 92:7 172:3,17 presenting 86:9 preservation 104:20 president 16:12 presume 82:22 pretty 9:1 40:9 45:12 70:11,16 78:21 79:21 96:9 103:15 112:19 133:3 158:25 160:2 previous 10:12 53:15 168:13 previously 10:16 39:1 90:4 107:11,16,22 129:17 145:24 168:18 182:4 price 78:18 primarily 41:8 47:22 179:1 180:19,21 primary 123:7 Prime 19:5,7 printout 87:5 prior 16:8,10 33:6 130:11 135:19 privileged 8:21 probable 59:20 problem 94:20 98:2 117:7 140:12 187:9 procedure 100:9 116:8 142:9 150:3,7 161:16 162:1,10 164:3,13,14 186:19 procedures 162:5 process 23:22 29:6 37:11 41:2 46:16 53:17 54:3 59:16 61:8,10 77:9 91:13</p> | <p>92:11 93:1,14 95:13 99:10 101:7 103:18 108:10 123:7 126:15 131:23 152:24 155:23 162:14,17,24 187:10, 11 processed 57:8 69:6 78:13,22,24 82:12 85:25 89:17 processes 17:17 58:11,12 62:1,4,8,15 processing 23:9 36:1, 2,6,8 47:18 57:6,12 85:8 99:5 174:9 produce 32:18 produced 40:24 179:10 products 34:11 professional 132:9 141:11 program 50:24 102:12 112:3 181:18 programs 181:6,7 182:1 progress 181:2 Progressive 26:19,21 project 180:14 181:9 projects 15:13,14,17 17:14 46:17 181:3 Properties 39:7 proposition 82:23 127:1 131:5 142:8,23 150:2,8 174:7 propriety 156:1 provide 48:15 52:2 55:5 58:18,21 59:2 64:12 66:2 67:13 70:4,25 77:5 81:12, 24 82:11 85:24 88:10 89:16 90:14,19,20,23 91:6,15 92:5,15,22 94:19 98:1,14 101:6 124:13 129:5,9 132:16,19,20 133:10, 18 139:23,25 149:16 150:16 152:23 164:11 169:17 provided 37:23 42:7 46:5 59:8 60:5 66:10 72:5,6 75:8,11,13,17 89:25 90:7,10 94:5 118:11,22 120:18 121:14 131:11 136:1,</p> |
|--|--|--|

| | | |
|---|--|--|
| <p>14 142:9 149:12 150:3,7 151:11 154:12 155:20 164:7, 19,21 provider 24:1 48:3,10 56:23 58:22 64:17, 19,21 65:2 69:5 70:15 74:13 78:17 90:8,18 91:14 98:22 100:13,17 101:16,21, 24 102:8,9 103:5,6, 13 105:25 117:14 118:1,4,8,12,14,16, 24 119:6,11,22,24 120:3 122:18 124:14 125:5 130:13,19 131:18 132:20,25 133:6,7,9,11,20,25 134:1,7,10,11 135:14 136:12 139:25 140:2 141:1 142:9 144:15, 16,22 148:13 150:3,7 152:2 154:14,24 155:6,16,25 157:14, 16 158:7,12,21,24 159:10,21,25 160:11, 22,25 161:10 162:23 167:8,10,12,16,20, 21,22,23 168:3 170:2,7,10,13,20 171:16 173:25 174:14,15,18,20 177:13,22 178:6,8, 18,23,24 183:1 provider's 90:13 100:14 101:5,25 103:16 133:18 160:15 providers 18:15 21:25 34:25 45:20 56:22 74:6 82:14 86:1 89:18 90:19,23 91:6, 9,10 99:16,19 101:12 102:11 103:21,25 104:9 106:7 112:9 119:11,14,15 123:10, 12 150:15 151:8,12, 20,21 156:18 157:8, 20 161:7 162:19 168:25 170:18 177:12,25 178:21 181:12 providing 20:10 83:24 109:18 146:13</p> | <p>public 14:4 32:5 46:12 publications 41:21 publish 112:10 published 51:3 113:1 publishing 112:18,20, 21 113:2 pull 162:13 purchase 16:21 purpose 23:20,22 35:7,15 56:19 57:3 58:19 59:5 70:21 77:4 88:3,5 89:13 153:4,5 155:17 put 68:9 76:23 126:5 142:21 puts 170:6</p> <hr/> <p style="text-align: center;">Q</p> <hr/> <p>question 7:10,11,12, 15,16,19,23 8:6 25:19 31:13,18 35:16 43:2 49:10,23 56:13 58:17 61:10,24 66:18 68:8 85:4,18 93:10 99:21 102:6,22 105:25 106:9 107:16 111:1 117:24 125:25 130:22 136:16 137:21 143:8 149:10 150:22 157:25 162:12 165:13 171:15 180:9 188:7 questionable 84:21 95:13 questions 12:2 24:19 58:1 66:5 70:14 80:3,6,20,21 82:4 84:20 85:4 86:10,20 87:19 88:9,12 93:19 94:1 97:18 98:8,13, 17 101:25 102:14 103:21 104:1 106:7 107:17,20 118:6 119:7,10 160:11 163:14 175:6,13 179:14 180:4 185:4 188:9,11 qui 18:14 quote 67:18</p> | <hr/> <p style="text-align: center;">R</p> <hr/> <p>Rachel 142:4 143:9 145:16 raised 30:6 102:14 raises 61:10,24 ran 16:10 range 50:14,22 163:15 RARC 112:13,15 113:1, 11 114:1 122:14,17, 19,22 123:9,14,16 rarely 35:11 rate 48:4 rates 21:24 38:2 47:19 ratio 105:14,17,21 reach 107:2,15 110:20 171:23 172:8 reached 176:7 reaching 172:5 read 32:10 48:18 52:10 53:19 83:12 85:22 121:6 130:15 136:25 145:16,18 146:12 149:1,8 151:6,7 162:22 182:14,25 reading 66:24 72:8 109:9 126:2,10 145:20 157:3 160:22 185:23 reads 69:25 155:5 real 84:8 realize 136:24 reasking 152:16 reason 9:20 10:2 20:7 28:4 51:19 52:1 57:11,14 58:2 70:4, 22,25 72:1 73:4 75:1 84:13,18 91:12 92:18 93:3,5 94:14,22 95:1,2 96:25 98:23 110:6 112:15 113:10, 14 115:11,13 116:24 124:9,16,17,21 126:17 127:20 130:21 131:6,9,10 136:17,23 139:15,19 142:15,24 143:22,25 144:12,18, 19 145:1,21 148:18,</p> |
|---|--|--|

| | | |
|--|--|--|
| <p>21 149:3,6,19 150:9, 10 151:1,14,16 152:5 156:19 171:10 172:24 reasonable 48:4,12 65:18 71:10 130:15 156:17 157:7 reasoning 58:22 reasons 57:19 58:10 69:1 71:13 88:12 92:24 124:2 125:8, 12,22 126:2,9,21 129:22 136:8,13 154:15 Rebecca 8:16 recall 12:6 27:7 receipt 94:11 133:4 receive 69:3 74:2,4, 6,8,22,23 110:16 121:23 130:9 133:12 134:5 135:18 137:4 172:8 187:6,7 received 21:12 53:13 60:12 69:10 74:12,15 104:10 119:10 120:10,25 121:18,19 130:11 131:20 132:24 139:3,6,9 140:8,14, 18 141:14 144:8 183:23 receives 98:22 100:24 170:20 receiving 64:8,18,25 84:24 100:17 141:4,7 171:23 recent 23:8 29:23 38:21 60:22 recently 17:14 23:12 53:24 recess 42:15 77:24 106:18 145:10 179:20 recipient 185:16 recitation 182:16 recognize 66:11,18 76:22 79:20 recognized 30:22,25 recognizes 104:24 188:1 recognizing 77:4 recommendations 25:7 recommended 24:13,15 25:12</p> | <p>record 5:18 6:17 7:2 42:14,17 77:22 78:1, 10 106:16,19 145:8, 12 175:1,3,8,14,19, 23 176:4,23,25 177:6 179:18,21 180:25 181:1 184:12 185:24 recording 5:17 records 9:5 132:14 174:22,25 175:13,17 176:6,18,20 recourse 147:10 recruited 16:22 reduce 58:1 Reed 5:22 11:6,8,13 12:19 40:25 refer 13:1 47:1 112:6,13 116:15 143:5 148:17 reference 88:1 89:21 110:9 116:18 142:7 176:3 referenced 8:25 51:4, 16 59:4 108:18 109:15 132:21 146:1 160:9 178:16 187:21 referencing 150:23 169:8 referred 148:23 166:13 176:11 referring 45:7,12,14, 23 46:19 47:3 49:14 50:6 54:16 60:20 62:24,25 67:16,19 76:11 84:5 85:2 100:3 107:21,23 110:2 143:2 154:7 155:3 156:20 159:1 169:4 171:18 183:16 refers 45:2 52:16 72:3 116:20 118:20 143:6 refile 100:10 refill 186:3 reflect 45:5 161:22 reflected 51:14,15 161:15 reflects 65:7 refreshing 40:16 regard 26:11 90:16 regular 188:15</p> | <p>regularly 187:10 regulations 67:9,16 reimbursable 66:21 67:1 69:14 70:5 73:5 75:4,5 79:7 114:23 115:4 116:1,7 117:23 150:13 156:23 163:6, 10,13,23 164:15,19 167:6,23 reimbursed 75:9,11,13 168:4 reimbursement 69:6 137:24 167:11 reiterated 97:1 reiterates 96:21 relate 15:13 30:8 32:22 43:11 45:11 58:15 63:3,19 87:15 154:8 171:15 173:6 related 8:11 9:5 11:11 15:15,23 17:15,16 20:22 25:7 27:25 28:24 29:1 30:20 36:7 38:5 41:24,25 46:17 56:6, 10 95:15 123:2,3 125:23 146:17 160:12 175:13 180:12 relates 11:22,23 35:24 54:20 58:23 61:11,13 68:7 73:16 85:15 89:14 120:1 164:17 167:3 relating 15:15,24 21:23 30:18 33:8 34:23 40:23,25 103:11 117:17 120:2 155:21 181:5,7,21 relation 10:8,18,24 56:6,16 relationship 63:5 relationships 104:20 relevant 38:9 62:19, 21 89:24 108:17,19 109:14,19,21 110:8 154:24 160:8 162:6 165:4 178:15 187:20 relied 49:24 143:21 rely 38:18 49:23 relying 49:9 remark 21:9,12,17 22:3,5 23:8,15,18,21</p> |
|--|--|--|

| | | |
|---|--|---|
| <p>24:3,5,8,24 25:7,12 31:12,14,16,21 32:1, 6,19 35:4,7,10,11, 15,24,25 36:3 40:23 41:4,7 48:15,22 49:13,17 50:9,11,13, 14,16,18,21,23 51:2, 5,6,13 52:5,10 54:4, 20,22 55:18,20 56:2, 11,16,19 57:2,10,11, 21 58:2,10,14,15,17, 25 59:10,21 61:9 62:20 66:19,20 67:13,23 68:8,17,20, 25 69:3,9,21,23 70:1,19,21 72:9,13, 18,20,22 73:14,17,19 74:19,22 75:1 76:24, 25 79:3 80:16,21 81:4,13,25 82:4,8 84:11,15,21 88:2,24 91:11 98:12,17 102:1 105:25 106:1,7 107:13 110:25 111:2, 4,8 117:1,2 123:23, 25 124:15 125:13,23 126:10,18,19 128:25 129:8 150:23 151:4 153:19,24 154:16 155:4,13,20 156:1,2, 7 157:20 158:18,23 159:9,15,20 160:12, 17 162:25 164:16 166:11 167:15 170:1 171:15 172:4,5,8,18 173:12 183:13,18,20 186:15</p> <p>remarkable 41:9 remarks 67:10 80:1 remember 9:2 19:19,25 24:15 25:10 33:18,22 34:5 47:16 49:23 51:8 70:12 87:9 109:7 116:2 122:5,7, 11,24 129:25 134:16 remembering 27:9 172:6 remittance 112:15 123:10,11 remittances 24:1 rendered 103:7 rep 175:7</p> | <p>repeat 93:9 165:12 rephrase 56:14 93:12 rephrasing 116:22 report 8:12,24 9:1,18 12:24 13:4 17:6 23:1,13 24:23 25:24 29:19 33:21 39:16,17 42:21,23,25 43:4,5, 10,13,25 44:3,4,6,8, 11,15,19 49:13 50:10,23 51:14,16, 18,20 52:14,17,20,22 53:2,3,5 55:23 62:24 68:6 74:3 82:10 90:1 106:25 114:22 126:17 142:10 152:10 165:4 168:21 173:11 179:6 reporter 5:5 6:2 7:7 127:3 142:2 168:9 188:17 reports 8:24 10:9 25:4 28:5 39:24 179:5,7,10 representation 11:3 representative 61:16 108:14 109:13 113:7 119:19 160:5 178:12 187:18 representing 12:19 represents 187:24 request 59:4,17,23 92:12 95:16 108:18 170:21 171:13 173:4 186:2 requested 120:16,22 121:8 130:18 131:11, 19 132:23 135:23 136:2,11,14 183:21 requesting 60:12 110:8 122:3 requests 135:18,21 require 23:18 required 13:23 44:21 57:1 95:24 101:9 121:25 132:16,19,20 133:16 170:1,11,14 175:20 177:17 183:7 requirement 173:21 174:16,17 requirements 11:25 44:21 45:2,7,9,14,16 61:12</p> | <p>requires 31:24 90:22 95:3 research 15:7 16:6 17:3,5 28:15,17,20 29:8 34:14 40:3,5,9, 12,13,20,22,23 41:3, 6,14,17 42:2 43:7,8 49:17 53:6,12,14 resolution 170:7 184:20 resolve 183:2 resource 91:18 99:23, 24 111:7 119:2 129:4 158:9 181:5 resources 77:1 180:15 respect 180:7 respond 7:23 8:6 62:1 73:10 82:7 102:13 130:19 132:12 133:23 135:4 141:16 responding 7:10 62:8 66:18 82:3 101:8 response 58:25 61:9 65:20 66:2 73:2 87:9 118:10,18,19 120:11, 25 121:9,10,11,18, 19,23 136:19 137:25 148:6 149:10 150:21, 24 155:11 156:18 157:8 172:25 184:10, 19 responses 56:24 57:9 58:2 118:18 responsibilities 30:9 101:20 responsibility 90:14, 17,21 101:5,9,12,25 112:21 117:13,16,18 133:18 137:23 139:23,25 141:1 153:12,13 160:15 176:14 177:3 responsible 16:13 48:9 102:3 140:20 144:15,17,22 157:14 159:11 rest 70:13 72:23 79:1 80:13 88:8 154:11 restrictions 46:21, 22,24 result 58:18 61:16,17 126:10 134:1</p> |
|---|--|---|

| | | |
|--|---|---|
| <p>resulted 20:15 retained 17:13 19:17, 21 23:20,21 25:17 27:21 33:7 retention 11:16 retentions 17:15 retried 37:3 returned 161:18 reveal 8:20 reverse 132:8 141:9 review 23:2,14,18 24:3 40:24 41:16 42:23 43:18,23 44:13 46:22 54:1,24 57:4 113:20 168:23 174:24 178:9 186:1 reviewed 8:11 21:16 22:3,4 23:10 42:6 43:20,21 50:13 54:25 55:2 111:2 122:6 123:21 169:7 reviewing 23:21,22 41:23 50:13 reviews 17:16 44:20 46:1,13 47:12 rewriting 24:6 right-hand 80:4,19 108:4 rights 101:20 Road 5:3,12 Robert 5:22 role 11:20 32:5,7 126:20 rough 188:13,14,15,17 RPR 5:4 rude 7:4 rule 38:16 ruled 38:23,24 rules 6:17 run 22:11 runs 172:6 Russell 26:18</p> <hr/> <p style="text-align: center;">s</p> <hr/> <p>sake 8:3 128:13 salary 28:24 Salt 92:12 93:15 sample 51:6 84:10 85:3,19 86:13,16</p> | <p>129:5,6 sat 44:12 satisfied 98:5 saved 34:21 Savercool 99:12 107:11 109:4,5 110:17 171:18 172:3 savings 88:21 schedules 47:19 school 11:24 Schwerin 146:23 149:11 scope 25:9 30:11 37:20 52:15 106:10 scripts 62:5 search 51:8 52:9 83:17,19 searches 52:12 Seay 174:3 section 52:16 87:19, 22 97:1 110:4 148:23 178:2 185:20 sections 88:1 secure 186:5 seek 76:3,12 147:4 152:24 181:20 seeking 41:2,3 97:14 107:3 181:21 seeks 186:9 selected 63:25 selective 55:3 self-service 186:5 Senate 35:1 send 131:2 141:1 182:19 sending 140:20 170:5 sends 69:4 122:3 senior 15:12 sense 81:6 99:24 101:1 102:23 112:8, 22 114:5 148:19 155:7 161:13 sentence 48:8 67:8 85:22 89:15 107:5 110:7,10,13 119:23 125:6,20,21 126:20 128:22 132:4 151:6,7 154:11 155:17 156:16 159:20 160:3 178:3 185:23</p> | <p>sentences 151:7 separate 25:20 164:8, 9 177:5 separately 9:6,7 36:15 69:13 70:2,5 73:5 75:4,5,9,11 80:25 98:18 115:3,18 116:7 117:23 163:5, 10,13,23 164:15,19, 22 167:5,23 173:9,10 series 80:1 serve 84:12 served 34:13 service 66:10,21 67:2 69:13 71:15,18,22 72:3,4 74:19,20 75:8,10,16 78:17 79:7,9 85:9 103:7 110:11 114:23,24 115:3,19,25 116:1,6, 9 117:23 118:20,21, 23 120:8 128:11,16 143:19 148:14 150:13,16 151:9 155:8 156:23,25 163:5 164:7,18,21 165:1,18 166:13,18, 20,25 167:2,3,7,9, 13,22 178:6 services 18:16 19:6, 7,12,13 22:18 33:5,8 37:23 38:3,4,6 46:5 56:7,10,17 75:9 76:6 108:23 127:17 130:6, 7 137:2 140:9 147:16 154:12 180:15 181:4, 5,24 187:6 set 24:18 76:7 sets 77:13 82:13 85:25 89:17 setting 69:14 70:6 72:5 73:5 75:4,12,14 86:25 115:4,18 116:7 117:24,25 118:19 163:6 167:23 settings 72:5 settled 19:18 25:25 37:4 Shah 5:25 share 173:25 sharing 177:4</p> |
|--|---|---|

| | | |
|--|---|---|
| <p>sheet 158:10 185:9 Shepherd 5:24 Shield 12:14,16 22:6, 7,8,9,17,21 47:17 51:7,13,20,25 60:23 short-circuit 175:5 short-term 88:20 Show 159:14 showing 148:13 shows 78:15 Shreveport 19:9 side 85:7 132:8 141:9 185:11 sign 46:11 87:17 88:8 89:5 182:18 sign-in 88:6,25 significant 6:15 20:8,15 115:16 121:2,4,15 171:22 172:2 similar 16:8 24:22 42:3 51:23 91:6 113:11 129:10 simply 152:23 simultaneous 87:1 sit 9:2 12:6 19:20 25:10 33:22 47:11 situation 11:24 60:3 61:5,14 63:19 103:12 154:1 155:4 157:17 159:24 situations 21:17,18 60:2 104:21 Sixteen 168:9,10 skimmed 43:24 small 16:25 17:4 20:14 smaller 51:25 172:18 Smith 5:22 11:6,8,14 12:19 40:25 Sodexo 19:12,13 sold 16:17 sole 74:3 75:10 sort 46:16 57:21 68:4,10 80:10 113:16 157:10 164:3 181:13 sorts 45:23 sought 76:18 169:1, 11,13 sound 137:5</p> | <p>sounds 72:11 112:19 source 38:16,18 82:6 89:22 112:24 115:12 160:13 sources 55:1 160:2,20 South 29:25 speak 7:21 9:8 10:3 68:10,16,19 91:9 speaking 62:12 103:22 175:3 specialization 13:22 35:24 specialized 13:20,21 14:3 20:11 36:7,10 specific 9:20 12:10 24:6 43:9 45:4,13 46:22 49:19 54:14 58:23 60:19 61:12,13 63:1 66:2 67:5,13 68:7 70:5 72:4 76:11 81:16 82:2 97:24 99:14 100:19 106:6 107:13 109:7 112:12 118:22 119:1 120:1 149:1,8 155:4 162:6 173:7 175:6,9,11 181:2 187:14 188:1 specifically 10:19 19:25 24:16,17 31:7 32:17 33:25 38:23,24 43:11,23 45:11 47:15 51:9 54:16,20 56:1 58:13 69:23 74:14 77:10 80:5 81:5 85:15 86:7,17 87:15 94:5 96:22 97:1,13, 15 98:15 99:17 103:11,22 107:21 110:9 111:3 112:4,5 118:12 119:18 120:1 131:4 135:17,21 141:4 142:18 146:17 154:8 155:3 158:9 169:8,13,16 173:6 174:24 181:12 specifics 65:4 134:17 specifies 169:10 spend 28:6 39:16,19 41:13,23 spent 16:14 spite 150:25</p> | <p>split 17:25 square 182:10 staff 15:12 25:2 39:23 40:2,11 53:20 standalone 122:19 standard 49:14,21,25 68:14 113:3,4,9 122:2,8 148:13 162:10 standardization 57:9 standardize 61:8 standardized 58:5,11, 12 59:1 62:1,4,8,14 111:16,17 standards 54:7,11,12, 15,17,21 57:5 76:7 111:12,13 standing 188:12,14 start 44:12 127:4 starting 93:6,14 124:3 137:15 185:1 starts 55:13 114:10 127:21 153:21 state 5:5 15:25 22:12 34:25 36:23 55:4 67:8,9,22 68:23 76:1 106:25 153:19,23 166:12 167:14 170:17 181:10,16 stated 53:1 140:22 statement 82:10 98:8 107:8 156:21 171:1 185:3,20 186:7 187:17,22 states 34:12 97:14 101:24 stating 139:10 statistics 104:11 status 141:8 statute 37:17 stay 184:23 186:18 steps 60:13 sticky 48:6 168:13,14 stock 30:5,14,16 stop 49:18 streamline 57:12 stricken 36:11,12 strike 70:20 105:24 structured 83:25 structures 76:4,19</p> |
|--|---|---|

| | | |
|---|---|--|
| <p>struggling 34:5 studied 32:2 Studies 16:11,16,22 study 71:8,9,11 stuff 142:11 subject 12:3 33:19 52:20 72:21 subjective 29:6 79:21 submission 21:24 23:22 93:3 120:2 123:9 156:14 160:21 161:7 submissions 146:15 submit 56:24 70:15 92:10 93:22,25 94:2, 11 95:7 96:3,12 133:7 137:23 147:1 156:4 159:3 160:15, 24 167:7,9,10,16 168:2 170:13 submits 170:10 submitted 38:24 53:22 56:23 59:12,19 60:25 61:19,21 65:5 66:9 67:1 69:5 71:2 92:24,25 95:25 96:17 99:12 139:2 147:8 154:13 156:9,10 161:25 164:18,20 submitting 92:11 93:2 95:12 108:16 109:13 119:20 144:15,17 147:22 158:24 159:11 160:7 167:11 178:14 187:20 subsidiary 14:20 26:24 sue 96:11 sufficient 48:7,8 55:5 64:12 84:12,17, 22 129:1 suggest 185:1 suggestions 24:4,6 Suite 5:3,12,16 summary 48:19 50:12 54:6 55:12 67:20 78:15,21 173:12 supplement 34:3 supplying 144:22 support 5:15 26:25 33:5,8 82:22 85:21</p> | <p>105:1 111:15 127:16, 17,22 150:8 172:22 173:3 174:6 180:22 181:18 supporting 85:23 supports 186:8 suppose 118:17 supposed 64:1 131:2 182:19 surgery 162:2 surprised 141:3 surrounding 154:2,6, 17,19 173:2 swear 6:3 sworn 6:6 system 14:21 23:9 57:12 66:8 67:4 112:12 151:19 158:14 164:3 systems 21:23 99:5 112:7 174:9</p> <hr/> <p style="text-align: center;">T</p> <hr/> <p>Table 55:13 tables 68:6 takes 28:20 83:13 taking 5:11,17 7:8 92:4 103:19 122:13 talk 7:9 36:15 54:7 66:7 158:20 talked 32:2 99:10 107:14,16,22 119:13 163:9 174:8 talker 7:20 talking 9:13,21 24:17 42:20 46:2 58:7 63:22,23 64:10 65:13,17 73:25 74:19 90:1 96:3,4 110:7 132:24 143:17 153:6 159:4 160:18 talks 77:10 96:20 119:3 135:9,13 tam 18:14 tasked 81:17 82:3 97:7 technical 94:25 95:1 113:22 Technically 59:10</p> | <p>telephone 62:5 81:21 110:21 125:3 tells 133:14 ten 25:22 41:15 42:4 127:3 179:15 tend 51:1 term 15:20,21 21:15 53:12 54:12,15 64:7 75:5,14 77:12,16,18 79:21 94:12,13 101:8 105:13,16 155:2 163:10 terms 9:11,14 28:9,12 42:24 43:11 72:12 75:18 104:18 117:7 125:15 153:6 171:14 172:16 test 164:12 testified 6:8 18:3,6, 9,20,24 19:2,7,9,13 20:5,25 25:16 26:3, 10,20 27:3,18 29:18, 21 33:4,10 34:6,15 35:3,6,9 86:6 134:14 180:9 184:25 testifies 135:1 testify 6:20 11:17 17:19 19:16,23 25:18 26:25 28:5 37:2 38:25 168:21 testifying 6:19 21:1, 13 34:19,23 36:21,22 134:25 180:7 testimony 17:25 18:1, 23 20:6,10,15,16 21:6 25:25 26:3 30:11 33:13,21 34:17,22 36:23,24 37:20 38:5 39:2 53:16 84:11 103:9 123:21,24 125:7,22 136:7 139:14 142:4, 13 143:6 145:18 146:3,21 149:25 178:17 tests 164:11 Texas 22:17 60:23 text 114:11,13 120:14 138:8 Textile 19:12 thing 8:5 9:13 16:10, 14 77:6 83:13 96:13</p> |
|---|---|--|

| | | |
|---|---|---|
| 115:19 117:19 121:3 178:11 181:13 things 8:20 15:21 30:19 43:3,14 45:23, 24 47:6 49:12 53:11 54:22 58:8,24 70:8 72:15 79:17 82:21 87:23 96:4 105:6 107:9 113:16 115:8 162:8 180:4 thinking 26:12,17 46:3 148:7 thinks 151:12 thirds 28:8 Thompson's 77:8 thought 79:19 126:14 thousands 55:24 time 8:1,4 11:1 16:14,25 17:3 23:11 24:11 25:18 28:6 29:9 30:16 36:16 38:10 39:9,11,18,21 41:8,23 46:15 59:10 92:25 104:8 106:13 119:12,15 123:10,12 125:18 130:9 132:13 133:24 137:4 140:11 141:17 147:4,19,22 150:24 180:20 185:25 times 18:8,20,22 20:1,3 25:17,22 26:10 39:2 84:17 99:13 107:12 148:16 title 15:11 109:7 titled 185:20 today 6:14,20 7:8 9:3,12 10:20 12:6 19:20 25:10 33:22 38:9 47:11 113:21 155:1 179:4,7 180:6 184:25 today's 8:10 9:9 10:4,14 told 131:2 140:9,11, 19 141:2 167:22 182:18 tool 52:13 top 19:8,11 30:1 39:6 80:4 86:9 93:18 97:17 107:16 110:3 153:21 174:4 184:25 185:2 | topic 41:21 total 60:6 78:16 105:19 177:3 track 173:21,24 174:12 tracking 176:8 training 14:3,7 35:23 36:7,10 transaction 161:3 174:14 transcript 188:15 transcripts 43:19 transition 147:25 treated 57:2 treatment 82:16 trial 20:17 trust 29:25 151:8 trustees 15:1 trusting 151:20 trusts 150:14 152:1 truth 6:6,7 turn 13:3 75:25 112:24 113:21 185:18 Twelve 29:17 type 24:20 44:6 61:3 170:22 types 11:21 15:14 23:17 40:20 146:14 typical 64:3,6 66:15 72:7 75:19 79:15 98:21 99:7,19 161:5 163:17 175:14 176:23,25 typically 61:23 69:3 101:15 103:13 122:16,17 | 168:24 172:9,24 173:5,20 178:5,7 182:17 UHG's 123:23,25 ultimately 38:15 47:24 71:12 undergraduate 13:12 underlying 28:6 underscore 127:8 understand 6:19,22 7:7,19 31:16,17 40:7 43:3 48:23 49:5,21 56:13 62:22 63:7,21, 25 64:13,15,23 66:9, 24,25 68:15 75:21 96:19 102:11,13 103:9 115:10 126:16 138:13,16 144:4,6, 14,24 146:8 152:8 155:7,24 157:13,14 158:17 161:11 163:12 167:1,25 170:3 understandability 63:11,13,15 79:21,23 114:5 163:15 understandable 50:2,4 63:4 67:11,24 68:3 75:19 79:15,19 111:23 113:25 114:4, 7 understanding 7:23 31:22 53:15 55:16,17 65:9 72:8 76:17 90:8 95:24 100:22,24 118:5 122:22 126:1 128:2 129:1 137:22 144:18,25 146:14,16, 18 151:18 156:8,11 158:13 161:6,21 175:12 184:8 understands 144:20 148:24 151:14 152:2 160:22 163:17,18 understood 7:16 80:10 124:2 125:7,12,14, 17,19,21 126:7,9,13, 18,21,23,24 129:22 130:14,16 131:6,8 136:8,23 139:15,17, 22 140:1 142:24 143:10,24 144:11 145:21 146:1,4 148:20 149:3,5,6,19 |
|---|---|---|

150:8,12 151:1,6,10
159:2 182:25 184:6
undertakes 111:14
uniform 93:4
uniformly 186:23
unique 187:8
United 9:8,12,19,22
10:7,13,23 11:5
51:10,11,21,23
53:16,17,20 54:2
55:20 56:1,4,9,15
62:7,11,18 64:19,20
65:1 68:9,16,19
74:11,15 76:14,18
77:7,9 78:18 81:8,17
82:3 83:17 88:8
89:6,22,25 90:11,14,
16,25 92:5 93:7 97:6
99:14 101:6,24
102:13 104:6 106:2
109:6 113:20,25
114:2 116:4,6 118:1,
2,5,8,10 120:6,23
121:11,16,23,25
122:3 124:14 128:19
129:9 134:5 135:19
137:24 139:3,6
140:10,19 141:18
146:4,12 150:7
153:16 154:24 155:25
156:8 157:19,24
162:17 164:23 166:2
170:6,14 174:21
175:9,11,12 177:24
178:17,20
United's 174:25
Unitedhealth 5:10,23
universal 94:3 174:10
universally 171:11
University 19:8
unusual 91:9
upper 80:19 108:4
uptick 20:8
user 89:5 97:24
usual 48:4,12

V

vaguely 122:7
valuation 20:12 21:1,
3 30:15 38:6

Vantage 19:9
varies 172:3,5,16,17
variety 45:24 46:17
47:6
vary 94:14
versus 5:9 19:6,12
29:25 30:5 36:20
39:7 115:18
vested 102:4,6,15
104:12 105:10
Video 5:17
video-recorded 5:8
videoconference 8:13
viewing 83:14
violation 38:15
visit 80:7,23 85:5
147:2,4,17 185:5
186:5
visited 80:25 89:2
visits 146:22 147:7
180:25
volume 57:7

W

wait 7:12 65:9 67:7
waive 177:17,21
wanted 38:3
wanting 40:6
Washington 26:19
112:18 113:2
ways 80:18 153:8
177:5 178:20
website 80:7,22 81:1,
3,7,18 83:11,14,16
85:6 87:5,10 88:7,10
89:1,3,13,21 93:20
97:21,24 98:5 110:21
164:25 165:17 178:5,
24
websites 84:19
weight 181:1
wheels 37:13
whistle-blower 18:14
wide 111:14
widely 180:20
wife 65:16 147:8
Williams 5:14
woman 180:24

women 146:15 180:17,
20 181:7,12
wondering 131:7
142:25
word 22:2 44:12
115:18 116:25 117:3,
6
worded 43:2
wording 64:16 65:6
117:22 163:20
words 62:23 63:3
126:5 155:2 165:20
work 15:13,17,18,19,
20,22,23,25 16:2,8
21:10,21,22 22:1,14,
16,20,24 23:5,20,23
24:2,7,20,22 25:2,3,
5,9 27:25 28:1,6,10,
25 29:2,6 32:21,22
34:10 37:19 44:10
46:6 47:17,18 103:17
147:24 180:10
worked 14:9,11 17:1,
8,11 24:25 34:4,10
48:11 60:22 76:13
99:9 100:13 105:2
174:12 181:3
working 11:8,13 15:6
22:10 28:8 45:5
60:17 61:2 98:19
99:2,4 107:10 174:9
works 95:19,23 96:9
158:14 161:6
worth 38:7
write 51:17 57:24
98:19 109:18,22
writing 94:2 95:3,17
written 23:1,13 24:23
25:4 29:18 32:8
43:25 47:9 96:5,7
123:20
wrong 63:9 64:17
65:10,21 72:11 101:5
139:2 157:18 185:2
wrote 44:12 155:19
www.myuhc.com. 185:5
186:6

X

X12 51:3,10,15 52:6
54:23 57:5 68:6

76:6,19,22,23 77:5,
11 111:5,10,11
113:19,22 116:5

Y

year 181:14
years 14:5,22 16:12
18:8,20 19:14,20
20:2,7,9,20 22:10,
23,25 23:10,12,14
32:3 34:18 65:14
171:3 180:11
yesterday 8:12 10:12
York 13:11,17

Z

Zipperian 5:24 6:11
8:22 9:17,25 11:2
12:5,22 13:1 42:10,
19 49:1 71:6 73:11
77:19 78:3,6,10
82:25 83:3,9 85:1
86:23 87:2,4 88:17
91:21 92:20 93:11
95:5 97:5 103:1
104:7 105:12,23
106:5,12,21 108:2
117:20 127:4,6
129:12,16 130:25
134:13,18,21 137:10,
20 141:20 142:1,3
143:4,11,23 144:3
145:6,14 149:21,24
152:22 153:15 158:22
165:7,14 166:1,6
168:7,10,12,17
175:2,10 177:11,19
179:13,17 184:14,16
188:6,10,18

Henry Miller, Ph.D.
January 11, 2019

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SIGNATURE OF THE WITNESS

I, HENRY MILLER, Ph.D., the witness in the above deposition, do hereby certify that I have read the foregoing deposition taken on January 11, 2019, and that the said deposition is a true and correct record of my testimony, with such corrections and changes, if necessary, attached.

Henry Miller 2/22/19
Date
HENRY MILLER, Ph.D.

(IF THERE ARE NO CHANGES, WRITE "NONE" BELOW.

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| PAGE LINE | READS | CHANGE TO | REASON |
|----------------|---|---------------------------|-----------------------------------|
| P. 34 line 21 | "No. That's fine. I saved the country." | s/B "No. That's fine." | - I didn't say the last sentence. |
| P. 105 line 17 | "enumerator" | s/B "numerator" | - typo |
| P. 113 line 17 | "not all insurance do" | s/B "not all insurers do" | - typo |
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