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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,

Plaintiffs,

vs.

UNITEDHEALTH GROUP INC., UNITEDHEALTHCARE, INC., UNITEDHEALTHCARE INSURANCE COMPANY, UNITED HEALTHCARE SERVICES, INC., and UMR, INC.,

Defendants.

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

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

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Videographer Jonathan Williams

I N D E X

E X H I B I T S

E X H I B I T S (Continued)

THE VIDEOTAPED DEPOSITION OF HENRY MILLER, Ph.D. was taken on January 11, 2019, commencing at 8:57 a.m., at 2575 East Camelback Road, Suite 1100, Phoenix, Arizona, before Helen Pasewark, RPR, CSR, CCR, CLR, CCRR, CR, a Certified Reporter in the State of Arizona.

THE VIDEOGRAPHER: Good morning.

This is the video-recorded deposition of Henry Miller, Ph.D. in the matter of Condry versus UnitedHealth Group Incorporated. This deposition is taking place at Gallagher & Kennedy, 2575 East Camelback Road, Suite 1100, Phoenix, Arizona, 85016, on January 11, 2019 at 8:57 a.m.

My name is Jonathan Williams. I'm the videographer with U.S. Legal Support located at 5757 Anton Boulevard, Suite 400, Costa Mesa, California.

Video and audio recording will be taking place unless all counsel agree to go off the record.

Would all present please identify themselves beginning with the witness.

THE WITNESS: My name is Henry Miller.

MR. DEEGAN: Robert Deegan, Reed Smith, on behalf of UnitedHealth Group, defendants.

MR. ZIPPERIAN: Nathan Zipperian of Shepherd Finkelman Miller & Shah on behalf of plaintiffs.

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THE VIDEOGRAPHER: Thank you. The certified court reporter is Helen Pasewark. And would you now please swear in the witness.

HENRY MILLER, Ph.D.,
having been first duly sworn to tell the truth, the whole truth, and nothing but the truth, was examined and testified as follows:

EXAMINATION

BY MR. ZIPPERIAN:

Q. Good morning, Dr. Miller.

A. Good morning.

Q. Thank you for being here today.

I know that you have given a significant number of depositions before, but I'm going to go over the ground rules just mostly for the record.

A. Sure.

Q. You understand that you are testifying here today in the same manner which you would testify in court? And by that I mean that the penalties of perjury apply here as if you were in court. Do you understand that?

A. I do.

Q. Okay. All your answers need to be audible.

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Uh-huh or huh-uh is difficult to determine what that means sometimes later in the record, so if you say uh-huh or uh-huh and I say is that a yes or is that a no, I'm not trying to be rude. I'm just trying to be clear. Okay?

A. Okay.

Q. You understand that the court reporter is taking down everything we say today, and that makes it important that we try to not talk over one another. I will try and let you finish responding to a question before I ask my next question, and I would ask that you attempt to wait until I've finished asking my question before you begin to answer it. Okay?

A. Okay.

Q. If you answer a question, I'm going to go ahead and assume that you understood the question. Is that fair?

A. Yes.

Q. If you don't understand a question or if you don't hear it -- I'm both a low talker and coming off a cold, so if you need me to speak up, let me know that and I will do that. I'll make sure that you hear and are understanding the question before you respond to it; okay?

A. Okay.

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Q. If you need a break at any time, just let me know. I will try and take a break about every hour or so just for convenience sake. If you need a break before that time, like I said, just let me know, we'll take a break. The only thing I would ask, if there is a question pending, that you respond to that question before the break; okay?

A. Okay.

Q. All right. What did you do to prepare for today's deposition?

A. I reviewed my file of documents related to the case and my report and I met with Mr. Deegan yesterday. And two other people were in the videoconference for that preparation.

Q. Who were those people?

A. Rebecca Hanson and Doug Hewitt.

Q. Approximately how long did that meeting last?

A. It lasted about five hours.

MR. DEEGAN: I'll just caution the witness at this point not to reveal communications. Some things are privileged communications.

BY MR. ZIPPERIAN:

Q. What consists of your file on this matter?

A. Well, it includes my report -- my reports and the documentation that's referenced in the notes to my

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report. I would say that that's pretty much it.

Q. Nothing else that you can remember as you sit here today that's in that file?

A. No.

Q. Do you have billing records related to this case in that file or is that kept separately?

A. That's kept separately.

Q. Did you speak with anyone at United HealthCare in order to prepare for today's deposition?

A. No.

Q. Okay. There may be a couple terms I use today, United HealthCare, UHC or UHG. Can we all agree that we're all talking about the same thing when I use one of those terms?

MR. DEEGAN: When you use that one particular acronym?

BY MR. ZIPPERIAN:

Q. In my mind it's UHC. I notice in your report you used UHG. I'm sure I'll say United HealthCare at some point. Unless there's a specific reason to specify, can we just agree that we're talking about United HealthCare, the defendants in this matter?

A. That's fine.

MR. DEEGAN: I think that's fine.

MR. ZIPPERIAN: Okay.

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Q. If that becomes an issue at any point for any reason, just let me know.

Did you speak with anyone in your office in order to prepare for today's deposition other than the attorneys that you've already mentioned?

A. No.

Q. Did you communicate with anyone at United HealthCare in relation to preparing either of your reports in this matter?

A. No.

Q. Other than the meeting and conference call yesterday, were there any previous either calls or meetings with counsel for United HealthCare in order to prepare for today's deposition?

A. I certainly had phone calls with them previously but without a focus on preparing for the deposition.

Q. Okay. So phone calls in relation to this matter but not necessarily specifically to prepare for today?

A. That's correct.

Q. All right. Approximately how many phone calls have you had with United HealthCare's attorneys in relation to this matter?

A. I don't know. I mean, it's --

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MR. DEEGAN: Over what course of time?

BY MR. ZIPPERIAN:

Q. Over the entire course of your representation.

A. I couldn't really give you a number.

Q. Okay. United HealthCare's attorneys in this matter is a firm called Reed Smith; is that correct?

A. That's correct.

Q. Are you currently working with Reed Smith on any other matters?

A. Yes. They're not active right now in that I'm not doing anything related to them right now, but the cases are still active.

Q. How many cases are you working on with Reed Smith?

A. I can only think of two.

Q. What's the nature of your retention in those matters? Are you being asked to testify as an expert in those matters as well?

A. In one matter that's correct. In another matter it's a consulting role.

Q. What types of cases are those?

A. Well, one of them relates to a different array of health insurance benefits and the other one relates to a situation involving a medical school and accreditation requirements.

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MR. DEEGAN: And I'll caution, Dr. Miller, to the point there are additional questions along these lines, if information is subject to confidentiality orders in those cases, just keep that in mind.

BY MR. ZIPPERIAN:

Q. As you sit here today do you recall the names of those cases?

A. No.

Q. Do you know --

A. Well, the specific names, no.

Q. Do you know either of the parties in either of those cases?

A. Yes. One of the cases, one of the parties is Anthem Blue Cross Blue Shield and the other case there's not been a lawsuit filed.

Q. Where's the Anthem Blue Cross Blue Shield case pending?

A. I believe in Kentucky.

Q. Reed Smith is representing Anthem Blue Cross in that case?

A. Yes.

MR. ZIPPERIAN: Let's go ahead and mark as Exhibit 1 to your deposition your December 11, 2018 expert report.

(Exhibit 1 was marked for identification.)

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MR. ZIPPERIAN: And we'll refer to that as Miller 1.

Q. I'm going to ask you first to turn to page 19. And that's part of Appendix A to your report, which is your CV. Page 19 lists your educational background and it says you have a Ph.D. in accounting and economics. Is that correct?

A. That's correct.

Q. When did you get that Ph.D.?

A. 1971.

Q. And you went to the City College of New York for your undergraduate degree?

A. Yes.

Q. What was that in?

A. Accounting.

Q. And then you got your MBA from City College of New York. Was that also, obviously, a master's in business administration?

A. Yes.

Q. Was there a specialized discipline that you specialized in while you were getting your MBA?

A. No official specialization, but most of the courses, other than the required courses, that I took were in accounting and economics.

Q. Do you hold any other degrees?

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A. No.
Q. Do you have any other certifications or specialized training since you got your Ph.D.?
A. I -- I did hold a certified public accountant license for a few years, and meaning that I passed that exam, but I don't maintain that license anymore.
Q. Do you have any medical training?
A. No.
Q. Have you ever worked in a medical facility, a doctor's office, or a hospital?
A. Well, worked certainly as a consultant on many occasions. I also was on the board of a hospital and chaired that board. I was never a direct employee of a hospital or a physician practice, but I have consulted with many.
Q. What was the hospital that you were the chairman of the board for?
A. Howard County General Hospital.
Q. Where is that located?
A. In Columbia, Maryland. It's a subsidiary now of Johns Hopkins medical system.
Q. What years were you the chairman? It's right here on your CV. Is it 1987 to 1989? Is that accurate?
A. That's correct.
Q. What were your duties as chairman of the board

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of trustees for the hospital?
A. Interact with hospital management, chair meetings, have oversight over the activities of the hospital in general.
Q. Your CV indicates that you are currently working as the managing director, health analytics at Berkeley Research Group. Is that right?
A. That's right.
Q. What do you do in that capacity?
A. I am one of several managing directors. Managing director title means that I am the most senior -- in the most senior category of staff. And what I do is work on cases and projects that relate to healthcare. Fairly broad array of types of projects, but all related to healthcare and almost always relating to health insurance issues.
Q. When you say work on cases and projects, does that mean work as an expert witness or consultant or is there some other work that you do?
A. Well, some of the work -- the term consultant is a broad term, could mean a lot of different things, but a lot of my work, but certainly not all of it, is related to expert witness or work or consulting work relating to litigation, but I also do a considerable amount of work as a consultant to other entities, state

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government health plans, occasionally hospitals.
Q. What percentage of your work is devoted to litigation currently?
A. Currently, I would say about 60 percent.
Q. What did you do before you were the managing directly at Berkeley Research Group?
A. I was a managing director at another firm, LECG, doing similar work. Prior to that I was a managing director at Navigant Consulting, which I did the same thing. And prior to that I founded and ran an organization called the Center for Health Policy Studies for 20 some years. And there I was president, responsible for the organization, but the bulk of my time was spent doing the same thing that I do now.
Q. Why did you leave the Center for Health Policy Studies?
A. Well, I didn't exactly leave it. I sold it to Navigant Consulting.
Q. Why did you leave Navigant?
A. The individuals who I was closest to and who had been active in the purchase of the Center for Policy Studies left Navigant to join LECG and recruited me to join them, which I did.
Q. And then why did you leave LECG?
A. Well, by that time there was a small group of

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us, the same people that I worked with at Navigant, who were interested in other opportunities and it was around the same time that Berkeley Research Group was being formed and so we became among the small group of founding members of the Berkeley Research Group.
Q. On page 15 of your expert report in the bottom paragraph, there you say -- it says:
"Dr. Miller has worked with more than 50 health plans, including some of the largest plans in the U.S."
When you say that you've worked with more than 50 health plans, what does that mean?
A. On a consulting basis I've been retained by them to do various projects. More recently those retentions have been related to litigation, but not always. And in the past they related more to reviews and evaluations of their processes or various elements of their activities.
Q. Do you testify as an expert for both plaintiffs and defendants?
A. Well, sometimes the plaintiffs are defendants.
Q. I'm sorry. Plaintiffs and defendants.
A. Oh, plaintiffs and defendants. Yes, I do.
Q. What would you estimate the percentage of your testimony is split along those lines?

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A. The majority of my testimony is for defendants, although it is -- there isn't necessarily a consistency. I have testified for health plans, for example, when they've been plaintiffs or defendants, so it's not exactly an easy comparison, but I've also testified in cases involving plaintiffs against health plans.

Q. In the last three years how many times have you testified on behalf of an individual plaintiff as an expert witness?

A. On behalf of an individual plaintiff? I can only think of one.

Q. What case was that?

A. That was a qui tam case, a whistle-blower case against DaVita, which is a one of the largest providers of kidney dialysis services in the U.S.

Q. Where was that case pending?

A. Georgia, I believe.

Q. Expanding on that a little bit, in the last three years how many times have you testified on behalf of a plaintiff who was not a healthcare plan?

A. Oh. A few times. Probably easier if you look at my list of testimony and I can tell it from that. And you're only interested in cases where I testified for a plaintiff but the plaintiff was not a health plan?

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Q. Correct.

A. Because I testified in a number of cases where there were no health plans involved.

Well, in one case listed on page 21 of my CV, there's a case, three up from the bottom, Prime Healthcare Services versus Blue Mountain Capital, and I testified for Prime Healthcare Services.

And on the top of page 22, University Health of Shreveport and Vantage Health Plan, I testified for the plaintiff in that case.

In the -- let's see -- four down from the top, Sodexo Laundry Services versus Angelica Textile Services, I testified for Sodexo, who is the plaintiff.

Over the last three years those are the ones that I can identify. I may have been involved in other cases where I didn't actually testify but which I was retained as an expert witness but the case may have been settled or whatever.

Q. Are there any cases that you can remember as you sit here today that in the last three years in which that was the case, with where you were retained as a consultant for a plaintiff who is not a healthcare plan but did not testify?

A. I can't think of any. I know I did that, but I couldn't remember specifically which ones.

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Q. Approximately how many times did that happen in the last three years?

A. I'd say four or five times.

Q. I noted that you had 68 cases listed on your CV in which you've testified or given deposition testimony, I believe, since 2011. Forty-six of those are in the last three years. Is there any reason why there's been such a significant uptick?

A. Yes. About four years ago I became involved in providing expert testimony in personal injury cases, a very specialized part of those personal injury cases dealing with the valuation of future medical expenses. The cases, as far as my involvement is involved, are fairly small. My involvement is fairly limited, but it has resulted in a significant amount of testimony. Mostly deposition testimony. Those cases don't come to trial very often.

Q. But there are lots of them; right?

A. There is lots of them, exactly. And I think they probably over the last three years may -- or out of all of the cases listed on my CV, they're -- more than half of those cases are related to those personal injury cases.

Q. I believe the number is 29 personal injury cases in which you've testified. In all of those cases

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were you testifying regarding the valuation of future medical expenses?

A. On the valuation of medical expenses and the applicability of Affordable Care Act coverage to the plaintiff.

Q. And was your testimony in all those cases for defendants?

A. Yes.

Q. Have you ever used remark codes for billing in any of your work?

A. Well, how do you mean used them?

Q. Distributed remark codes, received remark codes. I mean other than testifying about them as an expert.

A. Yeah, I've -- the term "used" is not -- doesn't really apply, but I certainly have reviewed and analyzed remark codes in situations other than as -- other than in litigation situations.

Q. And when was that?

A. Oh, it's been on several occasions. In the work that I've done for health plans, non-litigation work for health plans, a lot of that work is evaluation of existing systems that are in place relating to submission of claims and claims payment and rates at which payment is made to providers, and in the course of

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that work, for at least a few clients, I've -- I've evaluated -- evaluate is not quite the word -- analyzed remark codes that they've used. I've reviewed them.

Q. Who are those clients that you reviewed their remark codes for?

A. Mostly Blue Cross and Blue Shield plans: Blue Cross and Blue Shield of Florida, which is now known as Florida Blue; Blue Cross Blue Shield of New Jersey, which is Horizon Blue Cross and Blue Shield.

I've been working for more than 20 years as a consultant to a health plan in Oklahoma that is run by the state, the Oklahoma State Employees Group, which is actually a very large health plan. It's the second largest health plan in Oklahoma, and I've done that work for them as well.

Did some of that work as well for Blue Cross Blue Shield of Texas, which is part of Healthcare Services Corporation. Those are the ones that come to mind immediately.

Q. When did you do that work for Blue Cross Blue Shield of Florida?

A. That's been -- they've been a continuous client for probably 25 years or so, but I would say this particular work that I'm describing was done about three years ago.

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Q. Did you issue a written report to them in conjunction with your review?

A. No.

Q. What about for the healthcare plan in Oklahoma, when did you perform that work for that client?

A. That's been continuous. Some of that has been fairly recent, although I initially looked at remark codes as part of their overall claim processing system probably going back about 15 years, but I've reviewed them from time to time when issues have arisen and I would say most recently about two years ago.

Q. Did you issue a written report to them two years ago in conjunction with your review of their remark codes?

A. No.

Q. What are the types of issues that arise that require you to review the remark codes?

A. They're not -- they're not really difficult issues. The work -- I wasn't retained for the purpose of reviewing the remark codes. I was retained for the purpose of reviewing their entire process for submission and payment of claims. And in that work, obviously, one of the pieces of it is to examine the information included in explanation of benefits, in the EOBs, and

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that as well as provider remittances, and part of the work that I did -- that I was asked to do -- was to review the language in the remark codes that they use.

Q. Did you make any suggestions as to how they can change their remark codes?

A. Not specific suggestions such as rewriting them, no. My work was more focused on whether or not the remark code captured the intent of what was to be -- what was to be communicated.

Q. And did you determine that they did?

A. Most of the time.

Q. Were there instances where you determined that it did not and you recommended changes?

A. Sure.

Q. Do you remember what changes you recommended?

A. Not specifically at this point, no.

Q. And although we were talking specifically about the Oklahoma health plan in that last set of questions, is the same -- have you been doing the same type of work for the other plans or are there notable differences?

A. No. Similar. And -- yes, similar work.

Q. Have you issued a written report with regards to remark codes or potential changes to remark codes to any of the healthcare plans that you've worked with?

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A. No. These are all consulting assignments where I did my work, had staff do work and then made presentations on the findings of the work or in meetings or however, but there were no written reports for that work.

Q. Did any of the presentations contain information or recommendations related to remark codes?

A. Only to the extent that that was part of the scope of the work.

Q. As you sit here today can you remember any instance in when you gave a presentation that called for changes to remark codes or recommended changes to remark codes?

A. No.

Q. Over -- since 2011 you have 68 cases listed on your CV in which you've testified. Do you have any approximation of how many times you've been retained in cases but did not testify in that same time period?

A. Well, in order to answer the question, I have to separate the personal injury cases from the -- from my other cases, and in the other cases I would say probably eight to ten times. In the personal injury cases they would be many more, 50 or more. That's very common in those cases, for me to prepare a report and then the case be settled before there was testimony.

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

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of or in opposition to class certification? Or if there's a mixture, I would like to know what that is.
A. I testified in opposition to class certification.
Q. In each of the four cases?
A. Yes.
Q. And do you recall what the outcome was with regards to class certification in any of those cases?
A. If I'm remembering correctly, I think in three of the cases the class certification was denied and in one case it was approved.
Q. In which case was class certification approved?
A. In the last one that I mentioned in Pennsylvania for Health Net; but in the other cases that I mentioned, class certification was not approved.
Q. Is it accurate to say that you've not testified since 2011 with regards to class certification?
A. That's correct.
Q. Have you been retained as a consultant with regards to class certification since 2011?
A. No.
Q. Approximately what percentage of your current litigation work is related to personal injury case?

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

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

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implications in it. And the top case on page 21, the Jackson -- no, that's not -- oh.

The fourth case is the one I was trying to find. Lisa Allen and Misty Dalton on behalf of the Personal-touch Employee Stock Ownership Plan versus GreatBanc. Those both had ERISA issues raised and they've been -- I've addressed ERISA issues in a number of my consulting assignments as they relate to the responsibilities of health insurers when they're dealing with clients or customers that are ERISA plans.

Q. What was the scope of your testimony in the Innis case?

A. Both of the cases that I mentioned were cases where an employee stock ownership plan was disputing the valuation of the company of which -- that had been established at the time that the employees' stock ownership plan began, and both of the entities are ERISA companies and there are a number of issues relating to, among other things, health insurance, and those are ones that I was concerned about as they related to ERISA as part of the case.

Q. Were you recognized as an ERISA expert in any of those cases -- either of those cases?

A. No.

Q. Have you ever been recognized as an ERISA

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expert by a court?

A. No.

Q. Do you consider yourself an ERISA expert?

A. No.

Q. What do you consider the area of your expertise?

A. Healthcare finance in general and specifically health insurance, health coverage and measurement of the cost of healthcare. And in the broad area of health insurance I'm including Medicare and Medicaid.

Q. Do you consider yourself an expert in the use of remark codes?

A. Hard question to answer. I haven't actually been asked whether I'm an expert in that. Remark codes are not an area that generally demands that much attention. I understand remark codes. I understand how they're developed. I understand how they're used. I've never been asked the question whether I'm an expert in it before, so I don't know. Maybe.

Q. Maybe? What would you say makes you an expert in remark codes?

A. Oh. Well, understanding how they are developed and how they are used. I think that's what requires expertise.

Q. And what's the basis for your expertise in how

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remark codes are developed and used?

A. It's something that I have studied and talked about and presented on for several years.

Q. When you say you've presented on, is that in your consulting role or have you made public presentations regarding the use of remark codes?

A. No. In my consulting role.

Q. Are those written presentations?

A. No. Well, you know, they're -- do you mean is there a narrative that I've read from for the presentation?

Q. Or a PowerPoint presentation or something like that.

A. There are some PowerPoint presentations.

Q. Is that something that you maintain?

A. Sometimes.

Q. And specifically I'm asking if we asked you to produce presentations in which you've made presentation about remark codes, would that be something you'd be able to do?

A. No, because the work that those presentations relate to would be confidential work for a client.

Q. But it is something that you've maintained a copy of?

A. I may have. I don't know. I would have to go

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back and look, but sometimes I do, sometimes I don't depending upon circumstances. So I may have copies of one or more of those presentations, but I'm not sure.

Q. Have you ever testified in a case involving lactation support services?

A. Not prior to this case, no.

Q. Have you ever been retained in a case other than this one relating to lactation support services?

A. No.

Q. Have you ever testified outside of the personal injury context regarding the interpretation of the ACA?

A. In an expert testimony capacity?

Q. Yes.

A. I think so. I'd have to go back and look.

Q. There's a lot of them.

A. Yeah. And it's -- it's not as easy to remember. I would say I have, but in passing. It hasn't been the subject of the litigation, but it has been something that I would have -- that I did discuss as part of my testimony or a report.

Q. And as you sit here today can you remember what case that was?

A. Well, I have to think about it more specifically, but I know that there was -- there was a

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

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

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

A. About six, seven years ago.

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

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

Q. What was the nature of your testimony?

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

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

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

A. No.

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

A. No.

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

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

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

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

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

A. The use of remark codes is an element of

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

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

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

Q. Have you ever been stricken as an expert?

A. Stricken?

Q. Or excluded?

A. In two instances.

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

A. 2013 or 2014, around there.

Q. What was the name of that case?

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

Q. Who were you testifying on behalf of?

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

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

Q. Is that case listed on your CV?

A. Yeah.

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

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

Q. Yeah.

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

Q. The wheels of justice.

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

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

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

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managed-care plan and the Blue Cross of California had paid Children's Hospital at the Medicaid rates for those services and Children's Hospital wanted to get paid their full charges for those services, which were a lot higher, and my testimony related to what was the actual valuation of those services, what were they actually worth.

Q. That's actually fairly interesting but not particularly relevant to today.

Second time that you were excluded, when was that?

A. That was a case in Georgia where -- the case is the Ishmael case, personal injury case, where the judge was not very clear on why I was excluded, but ultimately I learned it was because of violation, in his mind, of the collateral source rule, which is a key element in personal injury cases, and that the defendant can't rely on the collateral source to pay damages. And of course it was not -- that's not what I do and that was not -- but that was what the judge decided.

I found it interesting that in the more recent case, the Gaddy case, which was also in Georgia, another judge ruled specifically, because the motion had been submitted to exclude me, specifically ruled specifically that I could testify on those same issues that I had

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been excluded from previously. But those are the only two times that I'm aware of that my testimony has been excluded.

Q. What was the name of the case in Georgia?

A. The one where I was excluded is Ishmael. It was -- it's on the top of page 23, Ashlie Danielle Ishmael versus General Growth Properties.

Q. Do you know how much Berkeley has invoiced to date for your time in this case?

A. I'm not sure. I usually look that up before a deposition, but I forgot to do that this time, so I'm not certain.

Q. Do you have an approximation?

A. And given that it would have to be a broad approximation, I would say 40- to $50,000.

Q. How long did you spend preparing the report, December 11, 2018 report, that's marked as Miller No. 1?

A. Do you mean how much time did I personally spend on it?

Q. Yes.

A. I would say, over an extended period of time, probably 40 to 50 hours.

Q. And do you have staff that assist you in preparation of expert reports?

A. Usually, yes, but not in this case.

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Q. And why not in this case?

A. Well, because the staff that I use generally I use for basic research and for data analysis and there wasn't really any data analysis to be done in this case for me and I did the research myself. It was just an issue of wanting to.

I like to understand the issue that I'm addressing as thoroughly as possible, so when the need for research is pretty general and I feel as though I'm not going to be learning anything new, I generally give that to staff, but in a lot of cases, like this case is, I do the research myself.

Q. Did you learn anything new in your research in this case?

A. Not really. I expanded my knowledge, clearly, but it's more a matter of refreshing my knowledge than it was learning anything new. And I say learning something new, I probably should say that this was just very interesting to me.

Q. Okay. What were -- what types of research did you do?

A. Well, mostly internet research and research relating to remark codes. And then the other research was review of documentation that had been produced to me by Reed Smith relating to declarations and depositions

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and explanations of benefits.

I did go through the process of seeking to identify -- doing research and seeking to identify how other insurers use remark codes as part of my interest in this.

Q. Okay. What did you do to research how other insureds used remark codes?

A. I maximized my Google time. I primarily used the internet. Found it remarkable that -- as I always do -- that there's so much there that you don't necessarily expect to see, but I was able to identify several EOB forms from different insurers.

Q. Approximately how many hours did you spend doing internet research?

A. Eight to ten hours maybe.

Q. Did you review any academic books, compendia, anything like that in performing your research?

A. No. I looked for them, but there really aren't any academic --

Q. Materials?

A. -- publications on this topic, at least not that I could find.

Q. How much time did you spend reviewing documents related to this case? And by that --

A. You mean documents related to this case?

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

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A. I don't think so, no.
Q. And that was a poorly worded question, but you understand I'm asking you if there were things that you looked at that you used to prepare your report that are not listed in the report itself?
A. Well, the answer to that is different. Certainly, I mentioned the internet research that I did and other -- well, it was all internet research, investigations that I did on specific issues, and certainly not all of that is listed in the report, but in terms of documents that relate specifically to the case, I believe that everything that I've listed in my report is what I looked at.
Q. Okay. Among the things listed are portions of depositions of some of the plaintiffs in the case; is that right?
A. Yes.
Q. Did you review the entire deposition transcripts for those depositions or just portions?
A. I reviewed -- in some -- well, in the cases of all the depositions I had for plaintiffs, I reviewed portions in some depth that I was directed to or that, you know, were specifically on point. I did review the entire depositions, but I skimmed a lot of the material.
Q. Was any portion of this report written by someone other than yourself?

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A. No.
Q. Was any portion of this report cut and pasted from another report?
A. No.
Q. Did you type the report yourself?
A. Well, yeah.
Q. Were there any drafts of this report before the final draft?
A. Well, the way in which I work, I am preparing the report, I don't have any drafts, but not to say that I sat down and wrote it word for word from start to finish just as it is now. It took a lot of review, but there are no formal drafts.
Q. How many iterations of the report were there before it was finalized, if you know?
A. I don't.
Q. I'm going to direct you to page 1 of the report. In the third paragraph of that page it says:
"I have also conducted reviews that required ERISA requirements regarding the clarity of communications between payers and insureds."
Do you see that?
A. I do.

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

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Q. For whom did you conduct the reviews?
A. Well, the one that I'm talking about right now, I'm thinking about right now, is for a client in a litigation context where the issue is how much should be paid and by who for out-of-network services provided to participants in the ERISA plan, and my work is being done for a health plan.
Q. Which health plan?
A. Don't know that I can say.
Q. Okay.
A. I did sign a confidentiality agreement and the case is not public yet.
Q. Any other reviews that you've conducted?
A. Well, it's been something that I've had to look at from time to time in many instances. It's just sort of part of the process of doing other -- doing the variety of projects I've done related to health insurance.
I would say that the issues that I'm referring to here are always health insurance issues and any restrictions that an ERISA plan document, which to me is what I would review, has any specific restrictions or limitations on the health insurer and whether or not those restrictions have actually been met. Of course, they're not always.

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Q. You refer to the clarity of communications between payers and insureds. When you say communication between payers and insureds, are you referring to EOBs?
A. Sometimes, but it also can be in benefit packages, you know, benefit descriptions, EOBs, letters. I mean, there's a variety of things, but EOBs are an important component of it. But I would say more often than not what my focus has been on is how the plan documents have been interpreted as written in a benefit booklet or a booklet that describes benefits.
Q. As you sit here today can you think of any reviews that you have conducted regarding the clarity of EOB communications between payers and insureds?
A. I would say that while it has been an issue in a number of instances -- it's hard to specifically remember cases, but, for example, earlier I mentioned the work I did for Blue Cross Blue Shield. I've done work on elements of claims processing, particularly fee schedules, rates of payment, for a number of insurers, and one of the issues that comes up in almost all of those cases is how are limitations going to be explained, limitations on payment or I guess primarily the issue, how is that going to be explained to insureds and what kind of a format. And ultimately it's the EOB, but frequently the benefit booklet is important because

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it may -- a lot of benefit booklets will indicate that, for example, if the participant uses a out-of-network provider, that the out-of-network provider is going to be paid at a usual, customary and reasonable rate determined by the insurer. And one of the -- one of the sticky factors that I've dealt with on several occasions is whether or not that information is sufficient -- not sufficient, but is clear, because the next sentence usually says you may be responsible for the balance for the out-of-network provider that was not covered by the plan. And I've worked with a number of plans on a description of usual, customary and reasonable in those benefit booklets.
Q. Are you aware of any benefit booklets that provide explanation regarding the remark codes that are found in the EOBs?
A. No.
Q. Have you read the Court's order on the motion for summary judgment in this case?
A. Yes.
Q. And do you dispute the Court's finding that the remark codes at issue in this case are difficult to understand?
MR. DEEGAN: Object to form.
THE WITNESS: Yes.

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BY MR. ZIPPERIAN:
Q. What's your basis for disagreeing with that finding?
A. Well, I don't think that they're difficult to understand.
Q. Well, we'll obviously get into that in much more detail.
Other than your opinion, anything else that you're relying on?
A. Well, that's kind of a binary question. I don't know that -- well, yes, I would say that there are other things besides my opinion. Most importantly, as I indicate in my report, that the remark code descriptions that the judge was referring to are industry standard descriptions. So that is the way in which the industry addresses those particular issues, and of course then my research into remark codes identified that --
Q. Let me stop you right there, if you don't mind, to get that specific point.
Do you believe that because they meet the industry standard, that they're easy to understand?
A. No. No. What I'm saying is that the -- if I remember your question correctly, what else did I rely on other than my opinion, and what I relied on other than my opinion is what the industry standard is, what

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

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

A. Yes.

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

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

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

A. Yes.

Q. Which insurers' remark codes did you examine?

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

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insurers. They tend to follow Medicare. And, of course, I looked at all the language in the remark codes that are published or established by the X12 organization that I referenced, but I also looked at the remark codes that Aetna uses and that CIGNA uses.

I found sample remark codes for a couple of Blue Cross Blue Shield plans. I did a fairly comprehensive search. And I don't remember all of them that I looked at, but I did specifically look at Aetna and CIGNA and compared them to United and CMS and X12 and compared them to United.

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

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

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

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

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

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

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

Q. Those are searches you conducted using Google?

A. Google is a great tool. Yes.

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

A. Em-hmm. I do.

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

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

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

A. No.

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

A. Yes.

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

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

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

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

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

A. Yes.

Q. Fairly recently?

A. Yes.

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

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

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Q. Did you specifically ask United HealthCare how many remark codes they use?
A. No.
Q. Do you know whether United HealthCare used any codes other than the four codes that we've discussed in relation to denying claims related to lactation services?
A. I don't know. I didn't investigate that.
Q. Do you know if United HealthCare had a policy related to claims related to lactation services and the codes, the remark codes, that they used to deny those claims?
A. I don't understand your question.
Q. Let me rephrase that.
Do you know if United HealthCare had a policy that dictated which remark codes they used in relation to denying claims for lactation services?
A. No.
Q. What's the purpose for insurers using remark codes?
A. Well, to communicate to insureds and to providers information about a claim that's been submitted. Both the insured and the provider get responses when they submit a claim, and frequently, but certainly by no means not always, there are explanations

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

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they were trying to reduce the number of questions or responses to remark codes, that they would have a reason for including all that information.

Q. But isn't that language the same for every EOB? Isn't it standardized language?

A. Yes.

Q. I think we might be talking about different things when we say individualized inquiry or at least in this particular area. I'm saying that isn't one of the reasons that health insurers use remark codes so that they can use standardized processes to deny claims?

A. Well, they can used standardized processes, I wouldn't say specifically to deny claims, because in a lot of instances the remark codes don't necessarily relate directly to a denial. You know, a remark code may say we need more information so that -- you know, if you're asking the question of are remark codes used to provide explanations that will result perhaps in fewer inquiries, that's their purpose. That's why they exist. I mean, they exist because of the insurer's desire to provide information back to the insured in the case of EOBs or to a provider as to what their reasoning is as it relates to a specific claim.

Q. There's a couple things I want to ask you about in that response. First one is: Don't the remark

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codes allow the insurers to use standardized language to provide information to the insureds?

A. Yes.

Q. And then you referenced a request for more information as a nondenial purpose for an EOB; correct?

A. Yes.

Q. Isn't it correct to say that the EOB is a denial unless there's additional information provided?

A. Well, it doesn't always say that. Technically, I think any time a remark code is used, it's an explanation of why the claim has not been paid as submitted. I don't -- to me that's not a denial. I mean, maybe other people -- it's just a use of language. Other people may look at that and say it's a denial.

To me, a denial occurs at the end of the process when the insurer determines they are not going to pay that claim. So, obviously, if you have a request for more information, I think anybody would assume that if that information isn't submitted, a denial is highly possible, highly probable, but it doesn't say that. Actually, there are some remark codes that do say it, but generally not necessarily so.

Q. But if you get an EOB that contains a request for more information and you don't give more information, will your claim be paid?

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A. Probably not. But I think that it's important to keep in mind that all of these situations, every insured situation is individual. You know, so that I have certainly seen instances where the additional information was not provided and that in the course of the total adjudication of the claim and communication with the individual insured, the insurer determined that it was okay to pay the claim. I mean, so it isn't automatic by any means. It's definitely based upon the individual circumstances.

Q. Can you think of an instance in which an insured received an EOB requesting more information and the insured took no further steps and the claim was paid?

A. I certainly couldn't name an insured for you without -- where that took place, but I can tell you that in my working with health insurers, I've come across such instances but without any knowledge of those specific insureds that was involved.

Q. What healthcare plan are you referring to in that?

A. A recent case that I've worked on that involved Blue Cross Blue Shield of Texas that comes to mind where the claim was paid but despite the fact that the additional information was not submitted. Actually,

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several of the claims that are involved in a case that I'm working on had the claim paid despite the lack of information of a certain type.

I think, as I said before, it's you have to think of the overall situation and environment in which claims are paid.

Every effort is made by an insurance company to standardize and automate the process, but once a remark code is issued and in response to that an insured raises a question, then the process becomes individualized as it relates to that insured, and the specific requirements of the insured are considered and specific decisions are made as it relates to that insured's situation and that includes a lot of communication directly between the insured and plan representative. And it may result, just in my experience, it may result in payment regardless of the fact that the additional information hasn't been submitted.

Now, if the additional information is submitted and there's no contact, then it's highly likely that the claim will be denied, but if there's contact, which is typically the case when an insured raises a question otherwise.

Q. Do health plans, in your experience, have

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standardized processes by which they respond to insureds' inquiries about claims denials?
A. Yes.
Q. Do those standardized processes include scripts for telephone calls?
A. Yes.
Q. Are you aware of United HealthCare using any standardized processes for responding to insureds' inquiries about claims denials?
A. No, I'm not -- I don't -- I'm not knowledgeable about exactly how United HealthCare approaches that. I'm speaking from my experience with other insurers.
Q. Do you know whether they have standardized processes?
A. I assume that they do.
Q. That's not something you asked anyone at United HealthCare?
A. No. It wasn't relevant to my opinions.
Q. Is whether a particular remark code is appropriate or inappropriate relevant to whether the code is difficult for an insured to understand?
A. I think I used the words inappropriate or appropriate in my report, and what I was referring to was something else. I was referring to whether or not

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it was the right code to be used for that specific circumstances. It didn't necessarily -- my use of those words didn't necessarily relate to whether it was understandable.
Q. And do you think that there is a relationship between whether the right code is used and whether that makes it easy to understand for an insured?
A. It -- well, that depends on the code. I mean, the fact that it's the right or the wrong code doesn't actually necessarily have a direct effect on the understandability. It may, but not necessarily.
Q. How would whether it's the right code affect it's understandability?
A. Well, I think that's you that's saying it affects the understandability. I'm not saying that it does. I'm saying it might.
Q. And I'm asking how might it?
A. Well, if one code -- if a code was used that did not relate correctly to the insured's situation, certainly that's going to be hard for the insured to understand why that -- what's being said there. So I'm not talking about the language in the code. I'm just talking about the fact that unless you have the right code, it's going to be difficult for somebody to understand why that code was selected or what that's

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supposed to mean, but that's independent of the language.
Q. Do you think the typical insured knows what a CPT or HCPCS code is?
A. Probably not.
Q. Do you think the typical insured knows what the term modifier or modifier combination is in the context of receiving an EOB?
A. No, but I do believe that the description -- we are talking about the description for the KM code. I do believe that the description for that code does provide sufficient communication for the insured to understand what needs to be done.
You don't have to know what all the CPT codes or HCPCS codes or modifiers are to understand. The wording there indicates that, you know, perhaps the wrong code was used, and that's a provider issue. And, to me, I think anybody receiving that would contact their provider or they might contact United and say what does that mean, and United would say to contact your provider. But I think that it's clear that -- what the code is intended to mean, and I don't think you need to know what CPT and HCPCS mean in order to understand that.
Q. Why do you think anyone receiving that code

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

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

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

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

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

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

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

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

Do you see that?

A. Yes.

Q. What ERISA regulations are you referring to there?

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

Q. Okay. You also state that:

"Remark codes are designed to be easily understandable by insureds."

Is that right?

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

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

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

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

A. No.

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

A. No.

Q. On page 4 you state in the first full paragraph:

"The remark codes communicate

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

Do you see that?

A. Yes.

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

A. Yes.

Q. And that says:

"This service is not separately reimbursable in this setting."

Do you see that?

A. I do.

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

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

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

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

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

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

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

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

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

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

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foundation for communication.

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

MR. DEEGAN: Object to form.

THE WITNESS: Overall? I have no idea.

BY MR. ZIPPERIAN:

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

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

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

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

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

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

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

A. Yes, I think so.

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

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

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

MR. DEEGAN: Object to form.

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

BY MR. ZIPPERIAN:

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

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

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

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

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

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

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remark code communicate the reason for the denial to an insured?
A. I think so. You know, it says it's not separately reimbursable in this setting.
Q. What does the term separately reimbursable mean?
A. Well, it means that in some instances the service that was provided is bundled together with other services and it is not separately reimbursed. In other instances it could be, if it's the sole service provided, it could be separately reimbursed, but what this indicates is this particular setting in which it was provided is not reimbursed.
Q. And what does the term setting mean in this context?
A. The location in which the service was provided.
Q. And you think those terms are easily understandable by a typical insured?
A. Well, I do, but I also think that if the insured does not understand that, that they're given plenty of direction on who to call.
Q. And that direction comes from the EOBs?
A. Correct.
Q. Turn to page 5. And in the first paragraph

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

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

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deposition of Dr. Henry Miller. We are on the record at 11:22 a.m.

MR. ZIPPERIAN: Let's go ahead and mark this as Exhibit Miller 2.

(Exhibit 2 was marked for identification.)

BY MR. ZIPPERIAN:

Q. Dr. Miller, can you tell me what Exhibit 2 is?

A. It is the explanation of benefits for Jance Hoy dated December 22nd, 2015.

MR. ZIPPERIAN: And, for the record, it's Bates-numbered UHC000873 through 876.

Q. Where in Miller 2 does it explain how Ms. Hoy's claim was processed?

A. Well, it explains it throughout. The first page is a summary. That summary shows that the amount that was billed with an explanation, total amount the provider billed for the service, and then it indicates that there was a discount on that price which United negotiated. And then the third item is how much the plan paid. And then it says how much you owe. So I think that it's a summary, but it's a pretty clear indication of how the claim was processed.

Q. What do you mean when you say how the claim was processed?

A. What was the disposition of the claim. And

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then, of course, the rest of the EOB provides more detail on those particular points.

Q. Let's look at the notes and the remark code. That's a KM code. Do you see that?

A. Yes.

Q. It says:

"This is not a reimbursable service. There may be a more appropriate CPT or HCPCS code that describes the service and/or the use of the modifier or modifier combination is inappropriate."

Do you see that?

A. Yes.

Q. And do you think that that language is easily understandable to a typical insured to explain why her claim was denied?

A. You know, one of the things -- and we've been discussing this issue and I've already answered it, I thought that this was understandable, this particular language, but I think at least I recognize that understandability is a pretty subjective term. So when I say I think so, yeah, but I cannot really measure understandability.

What I do think here is that this is a clear communication that identifies the issue. And, you know,

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then as I indicated before, there's a series of remarks that give you -- give the insured the information that they need to appeal, to ask questions, to -- and right at the top of the second page, in the right-hand corner it specifically says:

"Have more questions about your claim? Visit website for all your claim and benefit information."

So I think that, yes. Again, I can't tell you if Jance Hoy understood, because that's sort of an individualized issue, but I can tell you that there is effective communication in that code as well as in the rest of the EOB that gives Jance Hoy the opportunity to find out more.

Q. And how would a patient learn more about a remark code?

A. Well, there are a number of -- well, not a number. There are at least a couple of different ways. As I indicated, there on the upper right-hand corner of this form, it says, "You have more questions" -- that includes the remark code, you know, the questions that you may have, and identifies the website that you can -- you can visit to get more information, but there's also a phone number there and you can call.

Q. Let's take those separately. Have you visited

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the myuhc.com website?

A. Yes.

Q. And is there information on that website regarding remark codes?

A. Well, what I don't -- not specifically in a general sense, because it's intended to be a personalized website for people who are enrolled in the United plan and you have the opportunity to enter in your personal identification information, and I couldn't do that, so I couldn't get down to that level.

Q. So is it fair to say that you don't know if going to myuhc.com would provide a member additional information on their remark codes?

A. I can't, because I can't look at an individual -- an individual's information.

Q. Do you know if there's a specific department at United Health that is tasked with maintaining the information on the myuhc.com website?

A. No. I imagine there is, but, no, I don't know that.

Q. With regards to the telephone number, did you call that phone number?

A. No.

Q. Do you know what information they provide on that phone number with regards to remark codes?

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

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

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

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

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means by which members and providers can contact the health plan for more information, and that's what this does.

Q. If the design of the EOB was to initiate a dialogue between the insured and the insurer, as I believe you've testified to, why doesn't the EOB say that specifically?

A. I think it does. I think when you have right at the top of the key page describing presenting the EOB, it says, "you have more questions," do this. I think that's -- that's where the indication is that the dialogue is going to begin.

Q. Is there anywhere on the sample EOB that indicates that the EOB is not a final determination of the claim?

A. On the sample one, no.

Q. Is there anything that specifically indicates that the EOB is intended to be the initiation of a dialogue between the insured and the insurers?

A. Well, as I said, the "more questions about your claim," to me, is an initiation, an opportunity to initiate a dialogue.

MR. ZIPPERIAN: Let's go ahead and mark this as Miller 9.

MR. DEEGAN: Are we setting 3 aside or using

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them simultaneous?

MR. ZIPPERIAN: Maybe, but probably not.

(Exhibit 9 was marked for identification.)

BY MR. ZIPPERIAN:

Q. Miller 9 is a printout of the myuhc website log-in page. Do you see that?

A. I do.

Q. And I know I asked you this before, but I don't remember your response. Have you looked at this website before, even this page?

A. This page. That's as far as I've gone.

Q. Is there anything on this page that indicates where a member would find out more information about their EOB?

A. No. It doesn't relate specifically to a member's EOB. This is the page where the member would sign in and then more information would become available.

Q. It does have a common questions section on the far right. Do you see that?

A. Em-hmm.

Q. And it has a section in the middle that says "learn more about" and has a number of different things under that. Do you see that?

A. Em-hmm.

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Q. Do either of those sections reference EOBs or remark codes?

A. No. I don't think that's the purpose of this page.

Q. What do you think the purpose of this page is?

A. It's just -- it's the sign-in page that if you want to get information from the website, you need to sign in. And the rest of it is just an effort by United to answer questions that have come up frequently and just provide information on the use of the website. It's not intended to have more than that.

Q. Do you think questions about the reasons for claims denials is something that would come up frequently?

MR. DEEGAN: Object to form.

THE WITNESS: Yes, I do.

BY MR. ZIPPERIAN:

Q. This does allow members the opportunity to learn more about, for instance, health insurance for those not covered by employer, short-term health insurance, health savings accounts. Do you see that?

A. Yes.

Q. But no information on this page about EOBs or remark codes; correct?

A. No, but this is -- this is the sign-in page

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for a more -- a considerably more complex website.

Q. Have you visited the considerably more complex website?

A. No. I've already indicated that you can't do that unless you sign in with a user name and a password, and I'm not a United customer.

Q. You are assuming that it's considerably more complicated, but you've not seen it?

A. I am assuming it based upon my experience with other insurers where I do have the opportunity to access that information.

Q. Going back to Footnote 15, you list a CIGNA website. What's the purpose for listing that?

A. Well, again, the footnote relates to the sentence that says:

"EOB is designed to provide information about how a claim is processed and then sets forth the means by which members and providers can contact the health plan for more information."

And the reference to the CIGNA website, that's one of the -- another source in addition to United that provides that information.

Q. Is that relevant to what information is provided in the United HealthCare EOB?

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

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

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

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

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

Q. What documentation?

A. The documentation that describes what the issue is.

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

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

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

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

MR. DEEGAN: Object to form.

THE WITNESS: Whether there's a technical

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

BY MR. ZIPPERIAN:

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

A. No.

Q. What about over the phone?

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

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

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

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

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

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

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

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

A. I do.

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

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specifically reiterated in the section about appeals?

MR. DEEGAN: Object to form.

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

BY MR. ZIPPERIAN:

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

A. No.

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

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

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

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

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

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

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

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

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

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

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insureds about remark codes on EOBs?
A. No. It certainly doesn't indicate that they are responsible for that, but as I said before, they have a vested interest in doing that.
Q. And you are actually right into my next question. So what -- explain to me what the vested interest is.
A. Well, the provider wants to be paid and it will be a lot more efficient for the provider to be paid by the insurer as opposed to by the patient, and the providers understand this, whether they, the payer, is a government program like Medicare or an insurer like United, understand that the more they can do to respond to questions raised by the insurer, the more likely it is that they will be paid. I mean, that's their vested interest.
Q. Is it fair to say that they're entitled to be paid regardless of whether an insurer is paying or the patient is paying?
MR. DEEGAN: Object to form.
THE WITNESS: I don't know how to answer that question. Entitled, if you're asking that in the legal sense, I have no answer because I'm not an attorney. If you're asking whether they feel they're entitled to be paid, I imagine they do.

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BY MR. ZIPPERIAN:
Q. Obviously, not all patients have insurance; correct?
A. Correct.
Q. And when they go to a healthcare provider, the healthcare provider expects that they will be paid for the service rendered to that person; is that right?
A. Yes.
Q. I understand your testimony is that it's certainly easier if an insurer is paying; correct?
A. Yes, but I was specifically relating to a situation where there is insurance.
You know, typically, if you go to a provider and you don't have insurance, they may ask you to pay in advance, so that's pretty efficient. But if somebody has insurance, it's very much in the provider's interest to work with the patient in order to get paid, because introducing the insurance into the process certainly is more complex than just taking a check.
Q. Does an EOB advise members to contact their providers with questions?
A. No, not speaking specifically of the EOBs that I've identified, they do not.
Q. Are you aware of any healthcare EOBs that direct patients to contact their providers with

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questions about denials?
A. No.
Q. Why not?
MR. DEEGAN: I'm going to object to form.
THE WITNESS: I can't tell you why they don't. You'd have to ask somebody at United.
BY MR. ZIPPERIAN:
Q. Do you know what percentage of time members contact their providers for more information after they've received a denial?
A. I've not seen any statistics on that.
Q. Does a health plan have a vested interest in denying claims?
MR. DEEGAN: Object to form.
THE WITNESS: Well, I think that -- that there's a common feeling that that's the case, but in my experience, it isn't, because a health plan obviously has financial interests in terms of payment of claims, but they also have even greater financial interest in the preservation of customer relationships. So I think there are overriding situations that -- and I certainly have a good experience on this point -- overriding consideration where the health plan recognizes that denial of claims have to be done accurately and appropriately in order for them to

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maintain their support.
I can tell you that I have worked for large employers, very large employers, in their negotiations of contracts with health insurance companies and one of their main issues is whether or not they're going to get complaints from their employees about things like denials.
So, yeah, they have a financial interest in denials, but their interests are much broader than that and I don't think they have a vested interest in denying claims.
BY MR. ZIPPERIAN:
Q. Are you familiar with the term medical loss ratio?
A. Yes.
Q. What does that term mean?
A. It's a ratio where the enumerator is the amount of dollars expended in the payment of claims and the denominator is the total premiums that are collected.
Q. And how do insurers use that ratio --
MR. DEEGAN: Object to form.
BY MR. ZIPPERIAN:
Q. -- in their -- strike that.
If a provider has a question about a remark

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code, how do they get more information about that remark code from United HealthCare?

MR. DEEGAN: Object to form.

THE WITNESS: They also call and ask.

BY MR. ZIPPERIAN:

Q. And is there a specific department that answers questions from providers about remark codes?

MR. DEEGAN: Same objection.

THE WITNESS: I haven't asked that question. That would be outside the scope of what I was doing, so I don't know.

MR. ZIPPERIAN: I think it might be a good time to take a lunch break if everyone else feels the same way?

MR. DEEGAN: That's fine.

THE VIDEOGRAPHER: Off the record at 12:10 p.m.

(Lunch recess taken.)

THE VIDEOGRAPHER: We are on the record at 12:53 p.m.

BY MR. ZIPPERIAN:

Q. Welcome back, Dr. Miller.

A. Thank you.

Q. I'm going to direct you to page 5 again of your expert report. You state it is common -- this is

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in the middle of the page:

"It is common for members to reach out directly to the health plan seeking more information."

Do you see that? It's the last sentence in the third paragraph.

A. Oh. Yes.

Q. What's your basis for that statement?

A. Well, a number of things. Once again, my experience in working with health plans. Also, I mentioned previously the declaration by Savercool in which she identifies the portion of times that contacts were made for specific remark codes, and also there is direction on the EOB, obviously, that we've talked about before that directs the member to reach out, and previously I talked about the question on the top of the page about having more questions about your claim, but I didn't mean to exclude by saying that. There's a lot more information in the EOB about being able to ask questions.

Q. What are you referring to specifically?

A. Under notes we previously talked about.

MR. DEEGAN: Which exhibit are you referring to?

THE WITNESS: I am looking at the first of

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the exhibits on -- this might be No. 3, Jance Hoy.

BY MR. ZIPPERIAN:

Q. I think that's Miller 5. Is it Bates-numbered in the upper right-hand corner 887 on the first page? 877?

A. 877.

Q. 877. Yeah. That's Miller 5. Thank you.

A. In that EOB, after the information about the claim payment and the note, the KM note, the next paragraph identifies the appeal process and then it also indicates that if you're in a plan governed by ERISA, you have a right to file a civil action, but then it also says:

"You or your authorized representative, such as family member or physician, may appeal the decision by submitting comments, documents or other relevant information to the appeal address referenced above. You may request copies free of charge of information relevant to your claim by contacting us."

And then, you know, that's for the insurance company. It also provides information about consumer assistance, ombudsmen services. And then there's further information about appeals and meeting needs online.

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So there's a good deal of information that directs the member to contact the health plan right in the EOB, but the fact that they actually do that is on Ms. Savercool.

Q. Who's Savercool?

A. An employee of United HealthCare. I don't remember her specific title.

Q. Have you had any communications with her other than reading her declaration?

A. No.

Q. The paragraphs that you note on Miller No. 5 and, for instance, "You or your authorized representative may appeal the decision by submitting comments, documents or other relevant information to the appeal address referenced above" -- do you see that?

A. I do.

Q. Does that indicate to you that they are to write to that address providing information that they deem to be relevant?

A. Yes.

Q. And if they want more information relevant to their claim or copies of information, they should write to the P.O. box address?

A. Not necessarily. It just says "by contacting us at the above address," and the contact information

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includes a phone number.
Q. Do you think that above address is referring to the address at the top of the page and not the address in the appeals section?
A. I do.
Q. What's your reason for believing that?
A. Well, the sentence that we're talking about about requesting copies of information relevant to the claim does not specifically reference appeal. It's a more general sentence and, therefore, I think it applies to the service center.
Q. And is it fair to say there are two addresses above that sentence in this document?
A. Yes.
Q. Do you know what percentage of members who receive denials from UHC contact UHC about denials?
A. No. The Savercool deposition -- declaration, rather -- identifies the data in a different way. It wouldn't allow you to do that.
Q. Do you know if members reach out through the website, through telephone calls or by mail? Do you know the percentage of how that breaks down?
A. No.
Q. Have you ever advised a health plan in their design of remark codes?

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A. I think I answered this question earlier and indicated that I've reviewed and discussed the remark codes but I have not specifically participated in the design of the remark codes.
Q. What is your experience with the X12 organization?
A. My experience is that it's a resource that I've used in other instances as well to identify remark codes.
Q. What is the X12 organization?
A. X12 is kind of a branch, I guess, which used to be the National Bureau of Standards. I guess it's now called the National Standards Institute. It's a nonprofit organization that undertakes industry wide investigations and analyses to support the development and use of standardized coding, information, among other standardized information in a number of different industries.
Q. Including the healthcare industry?
A. Yes.
Q. And do you know if one of their considerations in creating the codes is that they be easily understandable by a layperson?
A. I don't know that, no.
Q. What's your experience with the CORE Code

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Combination?
A. The CORE Code Combination is also -- is a program of CAHQ, which is a nonprofit organization devoted to healthcare issues and it is specifically focused, the CORE component of it, is specifically focused on what they refer to as the intraoperability of electronic data systems between insurers and payers, in the broader sense, including Medicare and Medicaid and providers and consumers as well. But their concern is -- they do publish codes, but their concern is more focused on the communication between the parties and the healthcare system. It's healthcare specific.
Q. What do CARC and RARC refer to?
A. These are different -- CARC, claims adjustment reason codes, and RARC I guess would be the remittance of adjustment mixing codes and they are the codes that are used to describe actions on claims payment.
Q. What is the Washington Publishing Company?
A. Pretty much what it sounds like. It's an independent publishing company. They have taken on the responsibility of publishing coding information in a broad sense from within -- I don't know what they do with other industries, but within the healthcare industry, so they are a source to turn to if you want a compendium of codes.

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Q. Do you consider the RARC language published by the Washington Publishing Company to be the industry standard for coding language?
A. It is intended to be the industry standard and most participants in the industry either use it directly or make sure that the descriptions that are included there are representative of their own descriptions. So, yeah. It's a longer answer than necessary. Yes, I do think it's the industry standard.
Q. Is there a reason why a health insurer would use language that they find to be similar to the RARC codes but not the exact language?
A. Yes.
Q. What reason would that be?
A. I think that it's an effort on the part of insurers to do two things. One is sort of make it their own. You know, there's -- not all insurance do. There are some insurers that usually adopt the language as it is in the X12 coding descriptions, but insurers like United make an effort, I believe from my review of it, make an effort to, as I've said earlier today, turn the more technical language in the X12 information into language that is more applicable to a layperson.
Q. Is it your belief then that the language that United HealthCare uses is more easily understandable by

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

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A. Yeah.
Q. And the language on the EOB says:
"This service code is not separately reimbursable in this setting."
Do you see that?
A. Yeah.
Q. So is that just a mistake that you made in the chart? I'm only asking because those two things are different.
A. Yeah. No. I understand. I understand. No. The reason I chose -- hmm -- it may be a mistake. I didn't -- I may not have looked at the same source. I can't give you a reason as to why it's not exactly the same.
Q. All right. Do you find the difference in the language to be significant?
A. No. But there's a difference. The difference is the use of the word separately. Setting versus place of service to me would mean the same thing. So there's definitely a difference. I certainly wasn't intending that to be different.
Q. But the difference is not material to your opinion; is that correct?
A. Correct.
Q. Do you know where the language "this service

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

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

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your provider or you can ask, in this case, United HealthCare, and United HealthCare is probably going to give you an answer that would lead you to ask your provider anyway.

Q. So it's your understanding that United HealthCare would, if a member called with questions about a denial, that the member would be directed by United HealthCare to contact their provider?

A. That was not what I was saying. It's possible that that would happen, but the response that United HealthCare provided, whether or not they said specifically you should contact your provider, would be likely to lead the member to want to contact the provider.

Q. And why would it lead them to want to contact their provider?

A. Well, I think that the -- suppose the response -- you'd have to think about what the responses could be. But if the response is that the setting refers to the place of service and this particular item of service, we don't pay for that according to your benefit plan when it's provided in that specific place of service and I would -- you know, you don't have to tell somebody that they should contact their provider, but to me that's what I would do. I think most people

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would do that. And again, it may not be so specific, but even in the Breastfeeding Resource Center information where it talks about claims being denied, the instruction is to call our office.

There aren't that many people involved in a claim. There's the member, the provider and the insurer. And if you have -- if you have questions as the member, you only have your choice of two people to call, and you may call -- it would seem likely if you had questions about information that you received, you would call the provider. Providers get those calls all the time.

Q. I think we talked earlier about your experience with providers and your basis for saying that providers get those calls all the time. We don't have to go through that again.

A. Okay. And I would point out too that later on in the -- under the notes, it specifically mentioned that you or an authorized representative, such as a physician, may appeal by submitting comments and documents. And I think that too helps the insured, think about contacting their provider.

Q. You think that's the intent of that sentence, is to direct a member to their provider?

A. I think that's one of the intents. The intent

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specifically relates -- specific intent relates to the submission of information relating to an appeal, but I think it implies that your provider may have information for you.

Q. I'd like you to take a look at, on page 6, the B5 code. The B5 code language for United HealthCare says:

"Benefits for this service are denied. We sent a letter to the member asking for additional information. We have not received a response."

Do you see that?

A. I do.

Q. And the information or the text from the CRAC codes says:

"Information requested from the patient/insured/responsible party was not provided or was insufficient, incomplete."

Do you see that?

A. I do.

Q. So the CARC language indicates that information had already been requested from the patient and the language from United HealthCare says that they sent that information. Does not indicate that they have received a response. Do you see that?

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A. Em-hmm. I do.

Q. Is that a significant difference in your mind?

A. I think it says the same thing.

Q. So you don't think that it's significant?

A. No.

Q. And I think that the way I read it, the difference is that the CARC language indicates that information was requested and that it was either that the response was either insufficient or incomplete and there's no mention of a response, an incomplete response or insufficient response in the United HealthCare language.

A. Well, the language in the CRC is that the information was either not provided or was insufficient or incomplete. I don't think that it's significant, because the United HealthCare language says we sent a letter to the member asking for additional information, we haven't received a response.

If in fact they had received a response and the information was insufficient or incomplete, it doesn't really matter. You know, I think that the point here is that this particular code is being used by United when they don't receive a response. It is mapped to the CARC, because the CARC code description is the closest to the United code, but it isn't required that

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it match exactly.
Q. Do you know if there's a standard letter that United HealthCare sends out requesting additional information from members?
A. I'm trying to remember whether or not I saw it as part of the documentation I reviewed, because I vaguely remember, but I don't remember it clearly enough. I believe there is a standard letter, yes.
Q. I'm assuming, based on what you just said, that you don't know what that letter says?
A. I would say I don't remember what that letter says.
Q. Taking a look at the second chart, how are the RARC codes used in the second chart different from those used in the first chart?
A. The CARC codes more typically are sent to the member. The RARC codes were typically sent to the provider.
Q. Are RARC codes standalone codes?
A. Well, they can be. They're always part of a context.
Q. Is it your understanding you can have an RARC code independent of a CARC code?
A. I'm trying to remember instances where that's been the case. I believe it's possible, but I --

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usually not.
Q. How are the two usually related?
A. What do you mean by related?
Q. Or how are the two usually used in conjunction with one another?
A. The CARC is used in the claims adjustment -- claims adjudication process and, therefore, its primary use is for the member.
The RARC is used in the submission of remittance advices to providers most of the time. Remittance advices can also go to members, but most of the time they go to providers. So that is the context in which they're used. Yeah.
Q. Are RARC codes sent to members?
A. Well, they may be, but I don't know that the member would know that that's an RARC code. As you can see, frequently they're identical. So I don't know how you distinguish.
Q. On page 8 after the second chart in the written paragraph, you say that you:
"Reviewed deposition testimony and associated exhibits from plaintiffs regarding their individual experiences with UHG's remark code descriptions. That testimony confirms that UHG's industry-standard remark codes

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functioned as expected and that plaintiffs understood the core reasons of their denials."
Starting with the first part of that, that they functioned as expected, what you do you mean by that?
A. That they effectively communicated the point that they were intending to communicate.
Q. Which was?
A. The reason for the denial.
Q. Did they do anything else? Did they perform any other functions?
A. Well, the only other function that they could perform was to provide a basis for further discussion if the insured was to call United or their provider.
Q. Can a remark code both effectively communicate the reason for denial and initiate a dialogue about the reason for the denial?
A. Sure.
Q. Explain that to me.
A. Well, the code, the description, identifies the reason for the denial and that many people looking at the information that's included in the description I would expect would want to find out more so that they don't necessarily direct the insured to find out more, but it's obvious that if they do want to find out more,

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how they can do that.
Q. And it's your belief that the way that they would do that is go to myuhc.com or call the telephone number on the EOB?
A. Or call their provider. Yes.
Q. And then the second part of that sentence is that that testimony confirms that plaintiffs understood the core reasons for their deductibles. Do you see that?
A. I do.
Q. Is it your belief that the plaintiffs in this case understood the core reasons for their denials after seeing their remark codes?
A. Well, I don't know when they understood it, but in terms of the discussion in the depositions, that's what is clear. So I don't know if they understood them immediately or they understood them at a later point in time, but their comments in their deposition imply that they understood them.
Q. So just looking at that sentence, the second part of that sentence that plaintiffs understood the core reasons for their denial, is it your testimony that that's not related to how the remark codes functioned?
A. No. No. I'm not saying that at all. You asked me a question in such a way so as -- for me to

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determine whether they -- their understanding of the reasons for their denials was immediate upon reading the code or was later. I don't know what was going on in their minds.

Q. And I'm not trying to put any words in your mouth. I'm just trying to be clear about what you're saying there and I want to understood.

Are you saying that at some point the plaintiffs understood the core reasons for their denials but not necessarily as a result of reading the remark codes?

A. No, not really. What I'm saying is that in their depositions it was clear that they understood it, but I don't -- how -- you know, what their thought process was is not something I can tell you about.

Q. Okay. And what I'm trying to understand is are you saying in your report that the reason they understood their denial was because of the remark codes?

A. Well, it was certainly the remark codes played a role in that, but all I'm saying in that sentence is that the plaintiffs understood the core reasons for their denials. I'm not identifying how or when they understood it. I'm just saying that when they were deposed, it was clear that they understood it.

Q. Okay. And you cite a number of documents for

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that proposition. Let's see, where are we at? Are we at Miller letter 9?

THE REPORTER: Ten.

MR. ZIPPERIAN: Let's start with that one.

(Exhibit 10 was marked for identification.)

BY MR. ZIPPERIAN:

Q. Miller 10 is a letter from Felicity Barber to whom it may concern, Bates No. PL, underscore, FB000015. I'll ask you to take a look at at Miller 10 for a second.

A. Okay.

Q. Have you seen Miller 10 before?

A. I have.

Q. It's a letter that acknowledges that Ms. Barber's claims were denied and it is appealing the basis of that denial, that the breastfeeding support services support should be covered; right?

A. Correct.

Q. Where does it indicate in this letter that Ms. Barber knew the reason for the denial of her claim?

A. Well, she starts the letter by saying that she filed two claims for breastfeeding support and both were classified as parenting classes and then she's appealing the decision on the basis of that classification.

Q. Does it say that she's appealing on the basis

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that they were classified as parenting classes?

A. That's what I'm understanding from what she is saying.

Q. Where in the EOB would it tell her that they were classified as parenting classes?

A. Well, I don't know. I think that she may have conducted additional investigation to find that out. Let's see if we can find her EOB. This is an I3 -- or it's a 13, rather -- a 13 code. And it says:

"Your plan doesn't cover this nonmedical service or personal item."

And as to --

Q. Just for clarity sake, you are looking at Miller No. 8?

A. Yes. Page 3. And she provides additional information by saying that the nonmedical service that was identified, she's identifying as parenting classes, which implies to me that she may have had a discussion with somebody at United to find that out, but it seems clear that she knows why it was that it was denied.

Q. And when you say it seems clear, you're basing that on the first sentence of the letter?

A. Yes.

Q. Is there anywhere in the letter that Ms. Barber indicates that the remark code on her EOB

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offered her sufficient understanding for the basis of her denial?

A. No. It looks to my as though she must be a patient of a Breastfeeding Resource Center, because they provide a sample letter to their patients and a lot of the language from the letter, the sample letter, is what Felicity Barber used and that doesn't identify anything about remark codes.

Q. Does United HealthCare provide any kind of similar letter for their members to file appeals?

A. No.

MR. ZIPPERIAN: All right. Let's mark these as Miller 11 and Miller 12.

(Exhibits 11 and 12 were marked for identification.)

BY MR. ZIPPERIAN:

Q. Miller 11 and Miller 12 have been previously marked as Endicott 58 and Endicott 59.

A. Em-hmm. Yes.

Q. Can you tell me what about Endicott 58 and Endicott 59, Miller 11 and 12, indicates to you that Mrs. Endicott, Ms. Endicott, understood the core reasons for the denial of her claims?

A. Well, the -- again, if we can find her EOB. I don't remember which exhibit the Endicott EOB is.

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

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

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

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

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

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

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

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

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

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

Q. Where in these letters --

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

Q. Okay.

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

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

And a copy of this was sent to Christine Endicott.

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

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

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

A. I do.

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

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

Q. Yes.

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

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

A. Oh. Okay.

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

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

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

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

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

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

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

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

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

Q. How did she know that?

A. It's addressed to the provider.

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

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

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

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

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

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

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

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"The diagnoses on the form were accurate."
"How do you know they were accurate?"
"Because I was experiencing them myself."
"And did you choose them? Did you choose the diagnosis codes?"
"No. There's text after the codes that says what the codes mean."
"I'm just asking you if you chose them. The answer is no?"
"I didn't. Lori did the diagnosis."
"Sure. And do you understand what an ICD-9 code is?"
"Nope."
"Do you understand what an ICD-10 code is?"
"No."
"Do you know when ICD-10 codes went into effect?"
"No."
"Did you ever discuss ICD-9 codes -- did you ever discuss when ICD-10 codes went into effect with Ms. Atkins?"
"No."

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"Did you ever have a discussion with Ms. Atkins that she submitted the wrong codes?"
"Once I received the letter from United saying there was information missing, I contacted her and that was it."
"So you received the letter from United informing you that something was missing; is that what you said?"
"I only contacted her after I received the letter stating that my claim was going to be denied."
Do you see that?
A. Yes.
Q. And does that testimony indicate to you that she understood the core reason for the denial of her claim?
A. Yes. She understood that there was missing information.
Q. And is that the core reason, that there was missing information?
A. Yes.
Q. Do you think that she understood that it was her responsibility to provide that information?
A. No. I think that -- that it is the responsibility of the provider to provide that

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information. I can't tell you whether she understood that or not, but that's the provider that provides the information.
Q. And let's look at page 32, line 22 to page 33, line 12:
"And tell me about the first conversation you had with Ms. Atkins about the letters that you had received."
"So I told her that services were not going to be covered. And I had called United to see why and at that time I was told they had a problem with the codes. So I contacted Lori and I said that there were these letters that were addressed to her that I had received saying that I didn't have to do any -- I didn't have to do anything with the letters and that's when I found out she had actually never received the letters. So I circled back and called United again and was told at that point I was actually responsible for sending those letters to Lori to get the information that the letter stated was missing."
Do you see that?
A. I do see.
Q. Do you think that that's accurate, that it was

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her responsibility to send the letters to her provider?
A. Well, I don't know what she was told. I'm surprised by that, you know, that in Exhibit 11. It specifically says you're receiving a copy of this letter to --
"Dear Christine Endicott, you're receiving a copy of this letter to keep you informed about the status of this claim. The letter on the reverse side was sent to the doctor, facility or other healthcare professional."
Which would be the normal course of action. But I certainly have no knowledge as to whether or not Lori Atkins actually received it.
Q. Do you think the language in the letter to Ms. Endicott that says you do not need to respond or take any action at this time initiates a dialogue about her claim with United HealthCare?
A. No. That language does not.
BY MR. ZIPPERIAN:
Q. Let's take a look at --
I think we are on Miller 14 now.
(Exhibit 14 was marked for identification.)
MR. DEEGAN: The Endicott deposition, that was 13?

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MR. ZIPPERIAN: I think so.
THE REPORTER: Yes.
BY MR. ZIPPERIAN:
Q. So Miller 14 is deposition testimony of Rachel Condry. Do you see that?
A. Yes.
Q. At Footnote 18 you reference certain pages of her deposition for the proposition that Condry knew her provider provided the procedure code to UHG. Do you see that in Footnote 18 of your report under that big pile of stuff?
A. I see it.
Q. What about the deposition testimony that you cite, which is 8212 to 8301, indicates to you that Ms. Condry knew the core reason for the denial of her claim?
A. Well, let me find --
Q. And I'm asking specifically about the language that you cite.
A. I've got to find the Condry EOB. Has the Condry EOB been put --
Q. I don't think it had. And you cite this language, 8212 to 8301, for the proposition that plaintiff understood the core reason for denial of her claim, so I'm just wondering what in --

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MR. DEEGAN: Object to the extent that you are referring to a document that hasn't been entered as an exhibit yet.
MR. ZIPPERIAN: There is no document that hasn't been entered to an exhibit. He doesn't refer to the EOB. He refers to the deposition testimony.
THE WITNESS: Well, in order for me to answer the question, I need to know which code was used in the EOB for Rachel Condry, because that's what I'm opining as to whether or not she understood it.
BY MR. ZIPPERIAN:
Q. What about the language that you cite would change depending on the code that she --
MR. DEEGAN: I'll continue my objection.
THE WITNESS: Well, it's clear, as I assumed, that the code that we were -- the denial code that we were talking about is the KM code, which indicates that there may be more appropriate CPT codes that describes the service. And in 82 -- on 82 and 83 there's a discussion that -- there's a discussion about the need for an appropriate code, which is what I relied on. To me that's the core reason.
BY MR. ZIPPERIAN:
Q. And that indicates to you that she understood the core reason for the denial of her claim?

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A. Yeah.
MR. DEEGAN: Object to form.
BY MR. ZIPPERIAN:
Q. On page 83 she says "Did you understand" -- on 83, line 15:
"Did you understand that there was something not appropriate about the code that was used when you received this?"
"No. I honestly -- yeah, no."
A. Well --
Q. Does that indicate to you that she understood the reason why her claim was denied?
A. No, but that's not what I'm saying. What I'm saying is that she did understand that it was the provider that was responsible for submitting the code.
Q. And how does her knowledge that the provider was responsible for submitting a code indicate her understanding the core reason for the denial?
A. Well, the core reason for the denial was inappropriate code was used and she understands that a code was used, that it was not necessarily the correct code and that the provider is responsible for supplying the correct code. I don't know what more she would need to understand.
Q. And that to you indicates her understanding of

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the core reason for the denial of her claim?
A. Yes.
Q. And you get that from page 82, line 12 to page 83, line 1?
A. Yes.
MR. ZIPPERIAN: I think we've got DVD issues.
THE VIDEOGRAPHER: This ends Media 3 in the deposition of Dr. Henry Miller. We are off the record at 2:01 p.m.
(Recess held.)
THE VIDEOGRAPHER: This begins Media 4 in the deposition of Dr. Henry Miller. We are on the record at 2:13 p.m.
BY MR. ZIPPERIAN:
Q. Dr. Miller, I'm going to ask you to take a second or a minute to read pages 62, 63 and 68 of Rachel Condry's deposition, which is part of Miller 14. Have you read that deposition testimony before?
A. Yes.
Q. After reading that, do you think that Ms. Condry understood the core reason for the denial of her claim?
A. Well, that taken by itself really doesn't address it. What we discussed previously were pages 82 and 83 of her deposition, which were the pages that I

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referenced. I think that indicates that she understood, yes, but this does not necessarily.

Q. Do you think that that testimony indicates that she understood that United HealthCare was trying to initiate a dialogue about her claim?

A. Well, I -- I -- I can tell you that -- obviously, I can't tell you what she did or didn't understand, but I can tell you that it says right on the EOB immediately following the fact that the first claim was denied, that you have the right to appeal and it gives the instructions for the appeal. So I can't tell if she read it or not, but it's right there. United is providing the communication.

Q. What's your understanding of the types of claims that these women are making submissions for?

A. My understanding is it's for breastfeeding.

Q. And specifically for issues related to breastfeeding? Is that your understanding?

A. Yes.

Q. Looking at page 62 of Ms. Condry's deposition testimony, she's asked:

"How many visits did you have with Ms. Schwerin?"

Answer is:

"Three."

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"And you or your -- did you submit claims for the second visit?"

"We had already been denied for the first visit, and so we didn't at that time seek the other two because we'd already been denied the first one."

"Okay. So for Visits 2 and 3, no claim was submitted by either you or your wife?"

"That's correct. We felt that there would be no recourse if we had already been denied."

Do you see that?

A. Yes.

Q. And then on line 19 it says:

"Why did you not appeal the denial of the claim for the services for the first visit?"

And her answer is:

"I think at the time we were just really overwhelmed with what was going on in our lives and our new daughter. And by that point, you know, by the time we would have been submitting those claims, we would have -- both of us would have been back to work, and it was a very intense transition."

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Do you see that?

A. Yes.

Q. And later on page 63, line 11, it says:

"Were you aware that you had an option to appeal the denial?"

And her response is:

"Honestly, I'm not sure we were thinking about it."

Do you see that?

A. Yes.

Q. And then on page 68, line 2, it says:

"It was a letter that came with the kind of standard, you know, showing the provider and the service date and it said den- -- you know, item not covered. It didn't have -- I always find those quite perplexing. A lot of times they refer to a number. In this case it was whatever reason it was denied, it didn't make any sense to me. I didn't know why."

Does that indicate to you that she understood the core reason why her claim was denied?

A. That doesn't indicate it at all, but it clearly, the section that I referred to, pages 82 and 83, makes it clear that she understands that it was because an inappropriate code was used.

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Q. I'm going to ask you to read me the specific language that you think makes it clear to you that she understood that that was the reason her claim was denied.

A. She understood that the issue -- and this is the only reason that I used it -- she understood that the issue was coding.

Q. I'm just asking you to read the specific language that you think makes that clear.

A. Well, she says in response to the question "And did you ask Ms. Schwerin if there was or who provided the codes for the claim," and she said:

"I'm sure it must have been on Ellen's invoice."

She knows that a code is involved. She said, no, she didn't provide the code, but, then, of course, she wouldn't have.

Q. And that language indicates to you that she understood the core reason for the denial of the claim?

A. Yes.

MR. ZIPPERIAN: Okay. Are we on 15 now? This is Miller 15.

(Exhibit 15 was marked for identification.)

BY MR. ZIPPERIAN:

Q. Miller 15 is the deposition testimony of Laura

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Hipple, who is Laura Bishop. And you cite this excerpt of page 118, line 10 to 119, line 13 for the proposition that Bishop knew her provider provided the procedure code to UHG. Do you see that?

A. Yes.

Q. How does the fact that she knew that her provider provided a procedure code to United HealthCare support the proposition that she understood the core reason for the denial of the claim?

A. Well, the core reason for the denial of the claim was that an inappropriate code may have been used, and she certainly understood the first part, and it's not a reimbursable service. And even though she says she doesn't know what a CPT or HCPCS code is, she trusts that her providers knows what codes they should or should not use to provide the service. To me that indicates that she knew what that code was saying.

Q. And what was it saying?

A. It was saying that potentially an inappropriate code was used.

Q. So when she says on page 119 in response to the question, "Okay. And what did that indicate to you" -- and that's referencing the remark code, her response is -- "what it meant to me at that time was I have no idea what all this means, in spite of that, you

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think that she understood the core reason for the denial of her claim?

A. What I believe is that the language of the remark code, KM, clearly communicated to her that an inappropriate code was used. She may not have indicated she understood that in the sentence you read to me, but when I read the sentence two sentences later that says "What I trust is that my providers know what codes they should use or should not use to describe a service," to me means that she understood the communication that was being provided to her.

Q. So the fact that she thinks her providers should know what codes they should use indicates to you that she understands the core reason for the denial of her claim?

A. Sure. The core reason for the denial of the claim was that an inappropriate code may have been used.

Q. But if somebody doesn't have any understanding of how codes are used in the healthcare system, then what does her knowing that her providers or trusting that her providers should know what codes they should use indicate that they have an idea about why their claim is denied?

A. The communication in the KM description says that an inappropriate code was used. When she says

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Laura Hipple, when she says that she trusts that the provider understands what code should or should not be used, she's making it clear that that communication about codes was effective in what it intended to do, which was to tell her that was the reason why there was a denial. I'm not expecting that she would know which codes to use, nor does she expect it, but she does understand that an inappropriate code may have been used.

Q. Let's go back to your report. Do you know the outcome of the appeals of Felicity Barber and Jance Hoy?

A. No.

Q. Did you inquire about the outcomes?

A. No.

Q. Do you feel -- and I think you've answered this already, so forgive me if I'm reasking it, but do you feel that the EOBs encourage consumers to file appeals?

MR. DEEGAN: Form.

THE WITNESS: I would -- how would you define encourage?

BY MR. ZIPPERIAN:

Q. Whether they do more than simply provide information about the appeals process but in fact seek to drive members towards filing an appeal.

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MR. DEEGAN: Same objection.

THE WITNESS: I don't -- in that context I don't think that the EOBs encourage or discourage appeals. That would not be the purpose of the EOB.

The purpose of the EOB in the area that we're talking about in terms of appeals is to let the member know that if they feel as though the determination was not correct, they have multiple ways to address it. They can file an appeal. They are part of an ERISA plan. They can address it that way. They can contact consumer advocates. So I think that it's not a health insurer's responsibility to encourage or discourage appeals, but there is a responsibility to let people know how to do it if they want to.

BY MR. ZIPPERIAN:

Q. And you think United HealthCare EOBs effectively do that?

A. I do.

Q. On page 9 you state "Whether a given remark code" -- I'm looking at the third paragraph up from the top. Starts with "accordingly."

A. Yes.

Q. You state that:

"Whether a given remark code may have been appropriate or inappropriate in a

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particular situation cannot be determined without assessing the surrounding circumstances."

Do you see that?

A. Yes.

Q. What surrounding circumstances are you referring to?

A. The circumstances that relate specifically to the patient and the patient's claim.

Q. Which are?

A. As they indicate in the rest of that sentence:

"Including the services provided, the claims submitted, and the member's communications with the provider or UHG."

Q. Isn't one of the reasons that insurers use remark codes is to eliminate the need to assess surrounding circumstances?

A. No.

Q. Do insurers assess surrounding circumstances before issuing a denial based on the use of an incorrect code?

A. No.

Q. How is a member's communication with a provider or United HealthCare relevant to whether a code is appropriate?

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A. Well, I think earlier today I indicated that when I used the term or the words appropriate or inappropriate, I was specifically referring to whether the right remark code was used for a specific situation. If the member reads that and communicates with their provider, the discussion with the provider will help the member to understand whether or not that code made sense in the context of the service.

Q. That wouldn't change whether the correct code was used, would it?

A. (No response.)

Q. The member communication necessarily comes about after the code is used, right, or remark code is used?

A. That's correct, but the information obtained from the provider could be used in an appeal.

The purpose of this sentence, I'm not sure that you're interpreting it the way in which I meant it when I wrote it. What I'm saying is that after the remark code is provided, the particular circumstances relating to a member are critical to assessing whether or not the correct code was used. I'm saying it's just -- it's an individualized process.

Q. And I guess I don't understand how communications with a provider or United HealthCare would change the propriety of a used remark code.

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A. Well, the remark code once used is used. It's now on the EOB. But if in fact it's not correct, then that would be information that the member would submit on appeal and it could be changed.

Q. But the communication wouldn't change the circumstances that led to the remark code being used, it might change the understanding from United HealthCare about why a claim was submitted the way it was submitted; correct?

A. No. No. I think the increased understanding could in fact change whether or not the code was correct. It wouldn't give them any information necessarily about the circumstances for the submission of the claim.

Q. In the next sentence you say again:

"It is reasonable to expect that members will contact their providers in response to this denial reason."

And it's referring to the denial -- the first denial statement identified in the court's order which is:

"This is not a reimbursable service. There may be a more appropriate CPT or HCPCS code that describes the service and/or the use of a modifier or modifier combination is inappropriate."

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A. You kind of lost me. Where are you reading from?

Q. The next paragraph down. I'm sorry.

A. Yes.

Q. Why is it reasonable to expect that members will contact their providers in response to that?

A. Well, I think we can see that, certainly from Laura Hipple's deposition and sort of implied in one of the others, I guess Christine Endicott, I'm not sure which one it was, that even though they didn't understand what a CPT or a HCPCS code was, they did understand that the provider was responsible for identifying it. And if that's the issue, you would call your provider. You would contact your provider to find out how to deal with the situation that perhaps the wrong code was used.

Q. Does United HealthCare direct the members to contact their providers when they use that remark code?

A. No.

Q. Why not?

A. Sometimes I think it's -- I can't tell you. First, I can't tell you why United does or does not do that. I didn't ask that question. I don't know the

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answer to that, but it seems to obvious to me, to me, that would be what you would do.

Q. It seems obvious to you that that's what you would do, meaning?

A. That's what a member would do.

Q. The member would try to contact their provider?

A. Right. And, in fact, again, in the case of the Breastfeeding Resource Center, they specifically hand out a sheet of paper that says do that.

Q. Doesn't the expectation that a member will contact their provider without any direction to do so assume that the member has an understanding of how the coding system works?

MR. DEEGAN: Object to form.

THE WITNESS: No. They don't need to understand that, because all they need to understand is that -- what the remark code says, which is an inappropriate code may have been used. They don't have to know all of the details. That's why they would talk to the provider and ask them.

BY MR. ZIPPERIAN:

Q. But nothing in the remark code says anything about the provider submitting a code.

A. But it's pretty clear from, even from the

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depositions that we were just referring to a few minutes ago, that it's understood by most people that they know they don't submit the codes.

Q. Okay. So we're talking about three depositions?

A. Well, three depositions of three plaintiffs in this particular case, yes.

Q. Right. What I'm asking about is whether there's any indication in the remark code itself which would lead a member to believe that a provider is responsible for submitting a code or in the EOB generally?

A. Well, yes.

Q. Show me.

A. In the remark itself I don't think that there is a --

Q. What are we looking at here?

A. I'm looking at any one of the EOBs.

Q. Okay.

A. The remark code does not include the sentence you should call your provider. I think that that's something that is obvious.

I think I've said before there's only three parties involved in this healthcare claim situation, the patient, the provider and the insurer, and if the

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patient wants more information, there's two possible sources to get it at. I mean, that's pretty obvious.

But, also, in the EOB, there is a sentence that says:

"You or your authorized representative, such as a family member or physician, may appeal the decision by submitting comments, documents or other relevant information to the appeal address referenced above."

So, yes, I think that the member is directed to their provider if they have questions. It's not directly related to the remark code, but the EOB indicates that that's a source for them.

Q. What in the EOB would indicate to a member that it is the provider's responsibility to submit codes to the health plan?

A. Well, once again, the remark code that we're talking about, the KM code, says that an inappropriate code may have been used, and there are only three possible -- well, there are only two possible sources for the submission of a claim, either the patient or the provider. And the patient understands by reading that, certainly communicates clearly, that codes are involved and they know that they didn't submit any codes, so it must have been the provider. There isn't anybody else.

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Q. Do you think that members necessarily know that there are only three parties involved in the healthcare transaction?

A. Yeah.

Q. You think that the typical layperson has an understanding of how health insurance works with providers regarding the submission of claims?

A. Well, they don't have to know that. I think what they know is that they only have interaction with two other parties, their provider and the insurer. Yes, I think that people understand that.

Q. And that's just based on your experience?

A. No. I think that's based on common sense.

Q. What are CPT code -- what information is reflected in a CPT code?

A. CPT code identifies the procedure that is performed on the patient.

Q. Would a CPT -- would a claim be returned for a CPT claim not matching the patient's diagnosis?

A. Yes.

Q. But my understanding is a CPT code does not reflect the diagnosis of the patient.

A. That's correct.

Q. So explain to me how that would happen.

A. Well, if a claim was submitted that indicated

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that the diagnosis was a heart attack and the procedure code was back surgery, that would certainly be a good example of when the diagnosis on the CPT code did not -- did not mesh or they were not -- the CPT code didn't match the diagnosis. There are certain procedures that are relevant to specific diagnoses.

Q. And are -- is there something that's automated that correlates those things?

A. Yes.

Q. That's the standard procedure for health insurers?

A. Yes. And if there's a question, what health insurers do is they pull that particular claim out if the automated process doesn't identify it but yet there seems to be a discrepancy, and it's handled manually and individually.

Q. Do you know if United HealthCare has a process of its insurers that claim denials are sent to providers?

A. No, I don't. I assume they do. I mean, that's an implication that they do in the cover letter to Christine Endicott which we read before indicating that a letter was sent to the provider, but I don't know anything about that particular process.

Q. For the second remark code identified in the

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order on page 10, the second full paragraph down on page 10 --

A. Yes.

Q. -- it's:

"This service code is not separately reimbursable in this setting."

Do you see that?

A. Yes.

Q. I think we talked about before about what the term separately reimbursable means?

A. Yes.

Q. Do you think a layperson would understand what separately reimbursable means?

A. It's very difficult to answer these questions on understandability because of such a range of -- it's not a precise concept. So it's hard for me to answer whether or not a typical layperson understands the code. I think, though, understands what that means, but I do think that it is clearly communicated. I don't know, I can't think of other wording that would be more -- that would more clearly communicate the point. So I think it's as clearly communicated as it can be.

Q. Tell me again what separately reimbursable means.

A. Well, the way I described it before was that

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there are certain codes, CPT codes, or they could be HCPCS codes which are healthcare common -- that's the healthcare common procedure coding system, which is sort of an augmentation of the CPT codes, an extension of them.

There are codes that are only paid as part of another service. So if a service is normally provided, it is expected that there won't be a separate billing or a separate claim line for that particular code, that it is encompassed in another code. Sometimes that has to do with lab tests. I'm just trying to provide an example where a lab test would be combined with a another procedure.

But as an individual procedure, a particular code may not be separately reimbursable in some instances. And that's what this remark description relates to. For example, what I was just describing, if a lab submitted it and there was no other service being provided, then it would be separately reimbursable, but if a physician submitted it and it was part of the overall service that was being provided, it would not be paid separately.

Q. Are United HealthCare members informed that they can challenge the determination that something is not medically necessary by going to the myuhc website or

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calling customer service?

MR. DEEGAN: Objection. Form.

THE WITNESS: Well, I don't know that that is relevant to my report. I haven't discussed -- I haven't discussed medical necessity. I don't know where you're coming from with that.

BY MR. ZIPPERIAN:

Q. Fair to say that you don't know the answer to that?

A. Well --

MR. DEEGAN: Same objection.

THE WITNESS: I'd like you to repeat the question.

BY MR. ZIPPERIAN:

Q. Is a member informed that they can challenge the determination that something is not medically necessary by going to the website or calling customer service?

MR. DEEGAN: Object to form.

THE WITNESS: I think the words that you're using make it difficult. What do you mean by challenge? You know, they can call up and ask, but a challenge would be an appeal, and there's certainly enough information to identify the fact that they can appeal.

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BY MR. ZIPPERIAN:
Q. That's the only way in which a United HealthCare member can challenge the determination of medical necessity?
MR. DEEGAN: Same objection.
BY MR. ZIPPERIAN:
Q. Through an appeal?
A. They can challenge it informally, but if they want to challenge it formally, they have to file an appeal.
Q. With regards to the second remark code, you state that:
"The service code referred to is the CPT/HCPCS code included on the claim form."
Do you see that? The same place we just were --
A. Yes.
Q. How do you know that the service code is the CPT HCPCS code?
A. Because that's the definition of a service code.
Q. How would a member know that?
A. I don't think the member needs to know that.
Q. Do you think the member needs to know what a service code is?

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A. I think the member needs to understand the description, and the description says this service code, whatever it is, relates to a service. I don't know that they need to know the precise code. That's what is not being paid and it's because it's not separately reimbursable. I think that's effective communication.
Q. Would a member be able to submit a service code without contacting their provider?
A. No. No. The member doesn't submit service codes. The provider is the one -- they can submit claims for reimbursement if they're submitting them on their own and not through a provider, but they wouldn't necessarily use a service code.
Q. You state:
"The use of this remark code invites the provider to submit a corrected claim with the correct information."
Do you see that?
A. Yes.
Q. How does it invite the provider to do that?
A. Well, the provider gets the same information and the provider is told that the service code is not separately reimbursable in the setting and the provider would then know to look to see what the code is; is very likely to understand what the issue is. That's what they do to get paid. And if an incorrect code was used, then they would submit a corrected claim.

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Q. Does that assume that the provider should and can change the code in order to get reimbursed?
A. Well, can, yes. Should depends -- that depends on the individual circumstances.
MR. ZIPPERIAN: Let's go ahead and mark this as Miller --
THE REPORTER: Sixteen.
MR. ZIPPERIAN: Sixteen.
(Exhibit 16 was marked for identification.)
MR. ZIPPERIAN: I think it's the same as an actual previous exhibit without the sticky note. It's the same as Miller 12 without the sticky note on the front, I think.
MR. DEEGAN: Yeah, it looks like it.
BY MR. ZIPPERIAN:
Q. Miller 16 has been previously Bates-numbered UHC002378 through 2381. Do you see that?
A. Yes.
Q. In your report you testify in the last paragraph on page 10:
"Based on my review of case materials, UHG sent Ms. Endicott a letter that also was sent to her providers specifying the additional information sought."
Do you see that?
A. Yes.
Q. Is the case materials you're referring to there what's now been marked as Exhibit Miller 16?
A. Yes.
Q. Any other case materials that you reviewed?
A. No. That's what I'm specifically referencing.
Q. And is it your opinion that what's been marked as Miller 16 adequately specifies the additional information sought from Ms. Endicott?
A. Yes.
Q. What information is specifically sought from her in this letter?
A. Well, it's in the attachment, in the letter to Lori Atkins. It specifically says:
"Please provide the following information, ICD-9 diagnosis code, including fourth and fifth digit if applicable."
And that's...
Q. Do you think that Ms. Endicott knows what ICD-9 diagnosis code, including fourth and fifth digits if applicable means?
A. No, but I don't think she has to. What she needs to know is that additional information is

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required, and that's what the remark code indicates. The expectation is that her provider does need to understand what that is and I'm sure it does understand it.

Q. So is it your belief that by sending this letter, United HealthCare puts the impetus or the resolution of this claim on the provider?

A. Yes.

Q. And does it instruct Ms. Endicott to take any action in order to assure that her provider submits the required information?

A. No.

Q. But if the provider fails to submit the required information, United HealthCare will not pay for the claim; correct?

A. That's correct.

Q. You state:

"Often it's the providers" --

Same paragraph at the very bottom of page 10/

"Often it is the provider who receives the request for more information with an indication of the type of information that's needed."

Do you see that?

A. Yes.

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Q. What's your basis for that statement?

A. Just my experience in dealing with health insurers and healthcare claims over 45 years, that's the way it's done.

Q. How often is often?

A. Very often.

Q. How often is very often?

A. Almost always.

Q. All right.

A. The only reason it says often rather than universally is that there may be instances, they are not common, but there may be instances where there's a request for more information from the member, but in terms of the kind of information that we're discussing here as they relate to the remark codes in question, those would always go to the provider.

Q. On page 11 in the first full paragraph, you're referring to the Savercool declaration. Do you see that?

A. Yes.

Q. And it says that:

"A significant number of members do reach out to UGH after receiving EOBs and that some obtain adjustments in their claims."

Do you see that?

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A. Yes.

Q. What is the significant percentage?

A. It varies by -- when Savercool presented the information, it was by remark code and the percentage varies by remark code as to the percentage reaching out. And if I'm remembering correctly, it runs from a low of about 10 percent to a high of about a third of members who receive those particular remark codes reach out to UHG.

Q. You also say:

"Some obtain adjustments in their claims."

A. Yes.

Q. Do you know what percentage that is that obtain adjustments?

A. No. Again, that varies in terms of the way the information is presented. It varies for each of the various remark codes and it's a smaller percentage. It could be as high as 10 percent for one of the codes, but it's less for others.

Q. And you say that:

"This data provides additional support for my opinion that any alleged inadequacy regarding a denial reason used by UHG in response to a particular member's claims must

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be assessed on a case-by-case basis in light of the surrounding circumstances."

How does that data support that position?

A. Well, once the request for information comes into UHG and once appeals are considered, those are all investigations and decisions that relate specifically to the member. And based upon the member's specific circumstances and coverage and each case is therefore considered separately and differently. Well, not necessarily differently, but separately.

Q. Why did you limit your opinion in this report to the remark codes in the Court's motion for summary judgment order?

A. That's what I was asked to do.

Q. By defense counsel?

A. Yes.

Q. Again, On page 11 you say:

"In my experience" --

At the very bottom:

"In my experience, payers, such as UHG, can track when a cost-sharing requirement or other amount is assessed to a particular healthcare claim. Payers generally do not track whether a member was actually charged the cost share by the provider."

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Do you see that?
A. Yes.
Q. And you cite the declaration of A. Seay on the top of page 12 for that?
A. Correct.
Q. Any other support that you have for that proposition?
A. Well, again, we talked about my experience in working with health plans on claims processing systems and I would -- based on my experience, it's universal among health insurers, or all the health insurers I've worked with, that they can't track whether co-payments were actually charged or made because that's a transaction between the provider and the patient, and the provider may indicate that there's a co-sharing requirement and the insurer may know that there's a co-sharing requirement, but there's no way to know whether or not the provider actually asked for that from the patient or whether the patient actually paid. Only the provider would know that.
Q. What information is contained in United HealthCare's claims records?
MR. DEEGAN: Object to form.
THE WITNESS: I didn't specifically review United's claims records. I certainly know what's

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included in a claims record, but...
BY MR. ZIPPERIAN:
Q. Generally speaking, what's in a claims record?
A. There's quite a lot of information.
Q. Maybe we could short-circuit this and I could ask specific questions.
Does a claim rep --
MR. DEEGAN: Let's be clear on the record. General, not specific to United Health?
BY MR. ZIPPERIAN:
Q. Not specific to United HealthCare with the understanding that you have not seen United HealthCare's claims records and these questions are now related to the typical claim record for a health plan in your experience.
A. Okay.
Q. Do claim records contain information regarding the amount of money a patient paid out of pocket?
A. No. No. What the claim record includes is the amount of money that would be required to be paid out-of-pocket based upon the benefits available to the patient and -- but there's no information in the claim record as to whether or not payments were actually made.
Q. What about an insured's maximum out-of-pocket

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limit?
A. Yeah, there would be information, but it wouldn't necessarily -- there would be some reference to it in the claims record, but it would be difficult to follow there. That would be information that would be included in other records if in fact the member had reached a -- reached their limit. And certainly there's a tracking of that, but the tracking isn't based upon how much they actually paid.
When a claim is adjudicated, the insurer identifies an allowed amount, which is what is referred to in the healthcare industry. And that allowed amount includes the amount that the insurance company is going to pay and would be the responsibility of the patient. So when the insurance company is applying an amount to a maximum out-of-pocket limit, they're applying an amount based upon what the member would have paid according to their records, but they don't know if the member actually paid that.
Q. They don't have the member's bank records?
A. Exactly. Right.
Q. What about deductible amounts, would that be in a typical claim record?
A. Yeah, that would be part of the determination -- in a typical claim record there would

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be this allowed amount, the amount the insurance would pay and then there would be, depending on the insurer, either an overall total of member responsibility or an, you know, co-pay and other cost sharing could be separate. I've seen it both ways.
Q. Is the accuracy of a claim record important to a health plan in order to administer their coverage and benefits?
A. Sure.
MR. DEEGAN: Objection.
BY MR. ZIPPERIAN:
Q. Network providers are under contracts with health plans if they are an in-network provider; correct?
A. Yes.
Q. We established that earlier. Are they allowed to waive required co-pays or deductibles --
MR. DEEGAN: Same objection.
BY MR. ZIPPERIAN:
Q. -- for patients.
A. Is who allowed to waive them?
Q. A network provider.
A. It depends on their contract.
Q. Have you examined a United HealthCare's contract with in-network providers?

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A. No.
Q. Let's take a look at the conclusions section. In the second sentence of the conclusion paragraph, you say:
"UHG points its members to its website, its customer service or the member's provider."
How does UHG point its members to the member's provider?
A. I think we covered that earlier in the review of the EOB where it indicates that all the EOBs say the same thing here:
"Your authorized representative, such as a family member or physician, may appeal the decision by submitting comments, documents or other relevant information to the appeal address referenced above."
Q. And it's your testimony that that is United HealthCare directing a member to their provider?
A. Yes.
Q. Any other ways in which United HealthCare directs its members to their providers?
A. Not explicitly, but -- and, of course, they may direct them to their provider, may direct members to their provider on the basis of phone calls and website determinations. All of this is possible. But as far as

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the information that I examined, which was, primarily was the EOB, that would be the only place.
Q. Do you have any opinions with regards to this case that haven't been expressed either today or in your reports?
A. We didn't discuss my earlier report very much today. So there are opinions in there, but my reports include all of my opinions.
Q. Have you examined any of the other expert reports produced either by defendants or plaintiffs in this case?
A. No.
MR. ZIPPERIAN: I don't have any further questions unless there are follow-up questions.
MR. DEEGAN: Can I have about ten or so minutes?
MR. ZIPPERIAN: Yes.
THE VIDEOGRAPHER: Off the record at 3:07 p.m.
(Recess held.)
THE VIDEOGRAPHER: We are on the record at 3:22 p.m.
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EXAMINATION
BY MR. DEEGAN:
Q. Dr. Miller, I'm just going to ask you a few questions following up on a few things plaintiffs' counsel had.
Early on today plaintiffs' counsel asked you whether you had experience testifying with respect to breastfeeding or lactation issues, and I believe you testified that you had not. My question is: In your work as a consultant and in the healthcare industry for over 40 years, have you been asked to address issues related to maternal care or breastfeeding or child care?
A. Yes. Actually, in several instances. One project that I completed for the federal government, the Health Resources and Services Administration, was the development of what is probably best described as a diary for pregnant women and their infants through Age 1, so from the onset of pregnancy to the first birthday of their infants. This diary was created primarily for low income women. It was widely distributed at the time primarily through community health centers and it included a considerable amount of direction and support for briefing. It was a key component of the diary. And the diary was established in such a way that the woman who is using it could record doctor visits, record

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height, weight, other measures as well as record progress in specific activities like breastfeeding.
I also worked on a number of projects for the Bureau of Maternal Child Health Services, also as a health resource and services administration, relating to innovative programs, including a couple of different programs relating to efforts to encourage women to breastfeed.
And one other project that I would mention is one that I did for the State of New Jersey for their Department of Health in which they created a network of providers specifically for women who were on Medicaid who were pregnant. The same sort of thing, from the onset of their pregnancy through the first year of their child's life. They were considered to be members of this entity that was created by the State. And I developed a lot of the materials that were used to support the program.
Q. And by materials what do you mean?
A. I mean directions on when to seek care, why seeking care is important, what kinds of issues relating to your infant you should be most concerned about and the importance of breastfeeding.
Q. So breastfeeding or lactation services would have been accounted for by in your development in each

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of these programs?
A. Yes.
Q. Take a look at what we marked as Exhibit 12, the -- you have it previously marked as Exhibit 12. It's the Endicott November 26, 2015 letter.
A. Yes.
Q. Okay. Now, I know you familiarized yourself with this document earlier. If you want to take a moment to look at it again. Draw your attention to the first page. It looks like there's a square. Do you see that?
A. Yes.
Q. What may have been a Post-it note. And I believe plaintiffs' counsel read it out, and I looked for a cleaner copy and I agree with plaintiffs' counsel's recitation, which is:
"I called to UHG about this" -- arrow -- "I was" -- the sign arrow -- "I was told I was supposed to send this to Lori."
Do you see that language?
A. I do.
Q. In light of the -- first of all, how do you interpret that note?
A. Well, I interpret it as meaning that Christine Endicott understood that by being able to have and read

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the letter to Lori Atkins, her provider, that there was a need for more information to be able to resolve her claim.
Q. But there was some inadequacy based on medical information?
A. Yes. Additional medical information was required.
Q. All right. And if you'll look at what had been designated as Exhibit 7, the Endicott EOB.
A. I'm sure I'll find it.
Q. Do you see that on page 2 of 4 -- and, again, we discussed -- I'm sorry. You discussed this earlier with plaintiff counsel, the remark code B5?
A. It may take me a minute to find it here. Got it.
Q. I was referring to page 2.
A. Right.
Q. This is remark code B5?
A. Yes.
Q. This remark code indicates that additional information was requested?
A. Yes.
Q. And not received?
A. Yes.
Q. At least as of December 15, 2015?

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A. Yes.
Q. The date on there?
A. Yes. That's precisely what it says.
Q. And in conjunction with the note on the front of what's Exhibit 12, is it your opinion that Christine Endicott understood that there was missing information from her claim?
A. That is my understanding. And the dates match as well because on the October -- on the October 29th letter there's an indication that if there's no response within 45 days.
Q. Just for the clarity of the record, if you could just say which exhibit that is.
MR. ZIPPERIAN: I believe that's Miller --
THE WITNESS: It's Endicott 58.
MR. ZIPPERIAN: Which is Miller 11.
THE WITNESS: And Miller Exhibit 11. There's an indication at the end of the letter that if there's no response within 45 days, the claim will need to be denied, and that December 15th resolution is just a little over 45 days later.
BY MR. DEEGAN:
Q. And I guess we can stay on what we were looking at as Exhibit 7. All right. That's the Endicott EOB. You've testified today that at the top,

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starting on page 2 -- and I would suggest you can agree or correct me if I'm wrong. At the top of page 3 and 4 there are -- there's a statement:
"Have more questions about your claim? Visit www.myuhc.com."
Do you see that?
A. Yes. And it's also on the first page.
Q. On the first page as well?
A. On the cover sheet.
Q. And there's a phone number on the left-hand side also?
A. Yes.
Q. I would also draw your attention, in addition to those items -- I'm sorry. And in your opinion those -- that information helps establish or initiate a dialogue between the recipient of the EOB and UHC?
A. Yes.
Q. Okay. If you turn to page 3 of 4 of that same document, about halfway down the page you'll see a statement section titled "Meet your needs online." Do you see that?
A. Yes.
Q. Would you mind reading the sentence under that into the record, please?
A. "At almost any time day or night,

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you can review claims, check eligibility, locate a network physician, request an I.D. card, refill prescriptions, if eligible, obtain more information on EOB content and more. For immediate secure self-service, visit www.myuhc.com."

Q. Is it your opinion that that statement supports the -- your conclusion that there's -- the EOB seeks to initiate a dialogue about a claim?

A. Yes. That clearly is intended to initiate a dialogue.

Q. I'm sorry. Including about obtaining additional information on an EOB?

A. Yes.

Q. And the remark codes are content that is contained in the EOB?

A. Yes.

Q. In your EOBs -- I guess we can stay on this document -- included a procedure to initiate an appeal; correct?

A. Correct.

Q. Based on your experience in the healthcare industry, are appeals initiated uniformly by people with denied claims?

A. No.

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Q. And based on your experience in the healthcare industry, why not?

A. Well, because each person's case is different. Each member of a health plan has different issues that are going to affect their appeal and different issues regarding the services they receive, the coverage they receive, the information included in a claim. All of that is unique to an individual.

The problem is that when a health plan has millions of claims to process regularly, it needs a process that at least allows a portion of those claims to not have to be addressed individually. But when appeals are created, each one of them has to be addressed individually to assess the specific circumstances affecting the appeal.

Q. And so in your -- based on your experience, if we look at page 2 of 4 of Exhibit 7, the statement "You or your authorized representative, such as a family member or physician may appeal the decision by submitting comments, documents or other relevant information to the appeal address referenced above," does that statement address the individual nature of appeals?

A. It definitely does. It represents the need for the members appealing to build a file that recognizes their specific issues.

Q. And do you believe that it also addresses the individual nature of a dialogue that would be created by an EOB, such as, for example, the one we see at Exhibit 7?

MR. ZIPPERIAN: Object to the form of the question.

THE WITNESS: Yes, definitely.

MR. DEEGAN: No further questions.

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

I have a standing order.

MR. DEEGAN: We would like a rough, if we can get a rough. We will take the standing order for the regular transcript and the rough expedited. I don't know what phrase you guys use.

THE REPORTER: Did you want a rough also?

MR. ZIPPERIAN: Yes.

(The deposition concluded at 3:37 p.m.)

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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, Ph.D. Date

(IF THERE ARE NO CHANGES, WRITE "NONE" BELOW. PLEASE RETURN THIS WITHIN 30 DAYS OF RECEIPT OF DEPOSITION TRANSCRIPT.)

PAGE LINE	READS	CHANGE TO	REASON

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

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

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

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

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

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

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

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

Dated This 18th day of January, 2019.

Helen Pasewark

Helen Pasewark
CR No. 50905, CSR No. 6612, RPR

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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 2/25/19
HENRY MILLER, Ph.D. Date

(IF THERE ARE NO CHANGES, WRITE "NONE" BELOW. PLEASE RETURN THIS WITHIN 30 DAYS OF RECEIPT OF DEPOSITION TRANSCRIPT.)

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