Formerly The Foundation for Taxpayer & Consumer Rights
1750 Ocean Park Boulevard, #200, Santa Monica, CA 90405-4938 • Tel: 310-392-0522 • Fax: 310-392-8874 • www.consumerwatchdog.org

Tuesday, June 10, 2008

The Honorable Hector De La Torre
State Capitol, Room 3173
Sacramento, CA 95814

AB 1945 – Oppose Unless Amended

Dear Assembly Member De La Torre,

Since 2005, Consumer Watchdog has closely studied the patient impact and legal nuances of health insurance rescissions – retroactive cancellations of coverage – and has helped put a public lens to the problem in the media.

We are happy to see that your bill would require scrutiny of a proposed rescission before it can be carried out. Preventing wrongful cancellations is the best medicine, since the damage to one's health and finances of a loss of coverage cannot be fully remedied. We are, however, at a loss to explain your rejection of key patient protections after assurances from you and your staff that they would be included.

AB 1945 fails to even mention the one element most important to a fair and consistent outcome for patients: the standard by which rescissions will be judged. If companies are required to prove a patient committed fraud before rescinding, as the legislature intended, then the problem of wrongful rescissions would be largely self-regulating. Insurers and health plans would no longer bring "gotcha" actions against patients who never knew of, failed to appreciate the significance of, or forget some detail of, a past medical problem.

Your proposal to allow regulators to contract with outside companies to review proposed rescissions will put patients at a clear disadvantage because:

1) Your bill fails to address the standard on which the rescission will be reviewed and carried out. The health plans' already relentless attacks on the legal standard for rescission would be compounded in a third party review, where a company may use its unlimited resources to overwhelm and control the process.

    - No innocent patient should ever face rescission again. Rescission, because of its often dire consequences to the patient, should be reserved for those extreme instances where a patient lied on an enrollment application about a known health condition that would have caused the health plan to deny coverage (i.e. the condition was material to the health plan's underwriting guidelines). Even the

most independent and well-run review will not return a fair result if health plans and insurers are allowed to rescind coverage without a showing of a patient's "willful misrepresentation" before a rescission is carried out.

- Your bill, because it lacks a clear legal standard for review, will likely stack the legal deck in favor of health plans and health insurers. A clear legal standard for review would prove a sharp line that insurers would hesitate to cross. Without it, insurers will push hard to define a line of their choosing.

- Without a clear legal standard, even the most independent and well-run third-party review will not produce fair or consistent results if health plans are allowed to continue to rescind innocent patients simply because they were not aware of a detail of their medical record.

2) Its is inappropriate for a for-profit company that has no interaction with patients to be responsible for reviewing rescissions.

   - Such rescission reviews require a factual determination of a patient's mental state at the time he or she filled out an application for coverage, which is in stark contrast to the existing Independent Medical Review process that relies on a body of independently verifiable medical data to determine medical efficacy of a treatment.

   - In almost any other setting, a company or individual who wished to rescind a contract would have to convince a judge that the rescission was the correct remedy in a court of law, where both sides would be fully heard.

We agree that the difficulties of buying individual health insurance polices in California will not be fully solved until the state guarantees coverage regardless of an applicant's health condition. But the amendments called for and described below would, at minimum, ensure that patients can count on the coverage they bought and paid for.

1. Willful Misrepresentation & Intent to Deceive

We urge you to amend AB 1945 to clarify requirements under the law that a rescission cannot be carried out unless it is shown that a patient willfully misrepresented or intended to deceive the insurer about a known health condition when applying for coverage. The amendments below would also provide needed parity between the Department of Managed Health Care and Department of Insurance.

Health plans and health insurers argue that dicta in a recent Orange County Appellate Court Decision, *Hailey v. California Physicians' Service*, dba Blue Shield of California[1] allow them to rescind coverage without having to show that a patient willfully

[1] *Hailey v. California Physicians' Service*, dba Blue Shield of California (Cal. App. 4th, No. G035579)[hereinafter *Hailey*].

misrepresented information in her medical record. Health plans argue that they may rescind as long as they conduct an incomplete investigation prior to granting coverage, and if they do, the health plan may rescind coverage even though the patient reported all health details that he or she knew about. The Legislature must step in now to clarify the requirements of the law in order to protect patients from the absurd results of this interpretation because it may be years before the courts consider this issue again (*Hailey*, decided in 2007, was the first court case on Health & Safety § 1389.3, which became law in 1993.).

Consider the consequences of the health plan's self-serving interpretation of the law: A patient applying for health coverage makes an innocent omission on the application by not reporting a possible condition, such as a high blood pressure reading, that the patient's physician *never informed her about*. After submitting the application, the insurer completes "reasonable" medical underwriting but misses the physician's note in the medical file regarding the patient's high blood pressure. After the coverage is issued, the patient is diagnosed with cancer and the insurer authorizes a doctor to conduct emergency surgery. Once a bill for $200,000 is submitted to the health plan for payment, the health plan then does another more extensive review of the patient's records and finds the high blood pressure notes, which the doctor acknowledges not discussing with the patient. The insurer then rescinds coverage from the day it was issued, stating if they had known about the patient's high blood pressure, the insurer would have never issued the coverage. The patient must then pay the cost of the cancer treatment herself or, as is more likely, declare bankruptcy and possibly not receive treatment.

Some have argued that the solution is to better define what constitutes "medical underwriting" so that health plans are more thorough in their review. However, such an endeavor will ultimately lead to amorphous results and give health plans an opportunity to argue after the fact that their underwriting was reasonable. The clearest solution is a re-articulation of the standard that no innocent patient can be rescinded, with the burden on the insurer to show a patient lied about a past medical condition.

Patients do not go to medical school and are not aware of, nor would they likely understand, the import of much of the information contained in their medical records. Most never see their full records. The law requires that patients be honest about health conditions they are aware of, and requires health plans to do their own due diligence by conducting medical underwriting before issuing coverage, and to honor their contracts with patients once coverage has been granted. However, the scenario above, derived from a known patient experience Consumer Watchdog was involved in, makes rescission possible even though the patient fulfilled her end of the bargain.

An Impermissible Shift of Risk

The health plans' interpretation of § 1389.3 violates the Knox-Keene Act prohibitions against shifting the risk of coverage onto the patient. The Knox-Keene Act places the prospective financial risk of providing medical services on the insurer, which must demonstrate to the Director that it has, "[a]ssumed full financial risk on a prospective basis for the provision

of covered health care services . . . . Health & Safety § 1375.1 (2) (emphasis added). However, as discussed above, *Hailey* places the risk of a health plan's failure to conduct adequate medical underwriting on the patient who faces rescission even though the patient fulfilled her part of the bargain.

Proposed Amendments

New AB 1945 intent language: "The Legislature finds that in enacting § 1389.3, it intended that before any health plan contract is rescinded or cancelled due to an alleged mistatement or omission in the coverage application, or written information submitted on or with an application, there must be a showing that the misstatement or omission was the result of the applicant's willful misrepresentation and that the misstatement or omission materially affected the health plan's decision to issue coverage. The health plan has the burden of showing patients willfully misrepresented their health history."
New section to be added to § 1389.3: "No health plan contract may be rescinded or cancelled for a mistatement or omission in the coverage application, or written information submitted on or with an application, unless prior to the rescission or cancellation there is a showing that the omission or misstatement was the result of the applicant's willful misrepresentation and the subject matter of the omission or mistatement: i. materially affected the health plan's decision to issue the contract; and, ii. the enrollee knew of, understood, and appreciated the significance of, the omitted information."
Ins. Code § 10380 amendment: "The falsity of any statement in the application for any policy covered by this chapter shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive and it materially affected either the acceptance of the risk or the hazard assumed by the insurer."

DMHC's Support of A Willful Misrepresentation Standard in "All Cases"

The Department of Managed Health Care previously supported such an interpretation of the § 1389.3. For example, in a draft version of a regulation for post-claim underwriting, the Department proposed a clear standard to require a showing of willful misrepresentation prior to every rescission:

> (b) No subscriber contract shall be cancelled or rescinded because of a misstatement or omission in the coverage contract, unless the misstatement or omission is a result of the applicant's willful misrepresentation and the omitted information would have been a basis for denial of coverage pursuant to the plan's underwriting criteria, guidelines, policies, and procedures.

The Department now claims it is looking to the Legislature to address this issue. If indeed regulations are being held up in lieu of legislative action, it is doubly important that the Legislature get it right.

The Department's and Director Cindy Ehnes' own review of the problem provide some clear guidance for the Legislature. On January 29, 2007, prior to a hearing on health rescissions, Director Ehnes told a crowd of reporters, as reported by the *Los Angeles Times*, that the Department's position is *that the law banned retroactive rescissions unless a health plan could show that a policyholder intentionally lied about his health history on his application for coverage.*[2]

On page four of its *amicus curiae* brief for the *Hailey v. Blue Shield* appeal, the Department clearly articulated that,

> [b]ecause of the catastrophic consequences of losing health care coverage, and in furtherance of the consumer protection purpose of the Knox-Keene Act, the Legislature enacted § 1389.3 . . . . [which] expressly prohibits post-claims underwriting and allows a health plan to rescind coverage only in cases where it has met its burden of demonstrating that the consumer willfully misrepresented his or her health history.

(emphasis added).

2. Review of Rescissions

The review of rescission is fundamentally different from the review of medical care denials under IMR. When operating correctly, an IMR panel of medical specialists consider the relative efficacy of a doctor-recommended treatment compared to a lower-cost option proposed by a health plan by referencing independently verifiable medical data collected through clinical trials, professional journals, medical compendiums and the like.

The question of whether someone lied on an enrollment application is a legal determination – not a medical determination – and requires that reviewer have legal knowledge, like a judge or a regulator. A rescission is quintessentially an adjudication of a contract and a qualitatively different type of decision than a determination of medical efficacy under an IMR. The rescission review is essentially a weighing of particular facts regarding a patient's mental state at the time the application was completed. As such, unlike IMR, there is no universe of legal experience that informs the particular review at hand, only legal theories that may be applied to the particular facts.

The "facts" of a rescission review – whether a patient lied – require an exhaustive review of the rescinded patient, unlike an IMR that reviews the particulars of a diagnosed medical

[2] Lisa Girion, "Health plan review may be intensified; the state's top HMO regulator calls for outside oversight of insurers' attempts to drop policyholders," *Los Angeles Times*, January 30, 2007.

condition and does not require an interaction with the patient. Further, the great majority of rescissions involve the actions of regulators who often counsel patients about how to fill out the complex applications of the individual insurance – recommendations that are often colored by the insurance agent's financial incentives in selling coverage. Who would review the agent's action in the third-party review? Who would judge the weight of that evidence?

As such, it is inappropriate to subject a rescission to a third-party review that only relies on the paper record compiled by the insurer, allowing the patient little or no self-defense. Further, under a third party review, a patient would be at a significant disadvantage to make her case because unlike under IMR, the patient would not have the equivalent of a medical doctor to provide the needed assistance to effectively make her case.

Currently, the Department of Managed Health Care and Department of Insurance out-sources medical reviews under the IMR process to for-profit companies, like Maximus, which rely on health plans and insurers for repeat business. Financial incentives inherent in such a system weigh against the patient, particularly in reviews conducted by companies like Maximus that are in the business of providing insurance-related third-party reviews—which inevitably leads to complaints from patients that the process does not provide them due process though the insurers seem to have an inside track.

Health plans and health insurers know they can control an "independent" review if it is run by a business partner, regardless of whether the plans pay for the review directly or if regulators hire the reviewer on the health plan or insurer's behalf, as in the case of Maximus. Health plans and insurers also know, and certainly any third-party reviewer like Maximus fears, that the companies may at any time bring pressure to bear on the regulators and seek termination of a contract if a reviewer too often returns unfavorable results. In fact, the IMR review process under Maximus sides with health plans in 70% of the cases it reviews. That's why the companies have publicly supported such a system for rescission.

The existing third-party IMR process has come under increased scrutiny and criticism for failing to observe the appropriate statutory requirements when conducting reviews and the Department has been lax in its oversight. For example, in a recent IMR appeal in which a patient was denied access to a prescription drug because the health plan deemed it to be "experimental," the IMR made its decision without referencing, and apparently without awareness of, Health and Safety § 1367.21 which provides the legal standard for experimental drugs. Further, the Department has taken a very "hands off" approach to third-party reviews, providing, by all appearances, very little oversight to ensure IMR is operating the way it was intended.

Recommendation

Given the inappropriateness of sending this type of decision to an IMR-like third-party review and the growing concern about the ability of any third-party to be truly financially independent from health plans and insurers, we believe that it is inappropriate for your bill to propose such a system for rescission at this time. We proposed that instead of allowing the regulators to contract with a third-party to conduct such a review, that the regulators themselves

retain the responsibility. Regulators are sworn to uphold the law and can be more easily called to account if they fail in that duty.

Regulators must be allowed to contact patients directly when reviewing a rescission proposed by a health plan or insurer. Further, as with IMR, the results of the review should not cut off a patient's ability to go to court, and given the concerns about fairness, the results of the review should not be admissible as evidence in a legal challenge. It is only the threat of thorough legal challenges in the courts that preserves the integrity of the regulatory process as a viable alternative to patients.

Finally, by adopting the amendments proposed above regarding the standard for review, the number of annual rescissions would be reduced to a number that regulators can easily handle on their own. Lastly, public scrutiny of the regulator's action – through legislative oversight hearings and the like – is a much more transparent process than one that outsources that responsibility to a third-party reviewer.

Sincerely,

Jerry Flanagan
(310) 392-0522 ext. 319