



1750 OCEAN PARK BOULEVARD, #200, SANTA MONICA, CA 90405-4938
TEL: 310-392-0522 • FAX: 310-392-8874 • WWW.CONSUMERWATCHDOG.ORG

Thursday, September 21, 2006

Cindy Ehnes
Director, Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

RE: Single Fine Far Too Little to Correct "Retroactive Rescission" Epidemic

Dear Director Ehnes,

We listened to your announcement this morning with interest and were happy to hear you issue a \$200,000 fine against Blue Cross for a single case of the company's widespread practice of illegal policy cancellations. Dumping patients after they had paid premiums and been approved for medical treatments makes a mockery of insurance and must be corrected. However a \$200,000 fine is pocket change for a company that recorded a \$185 million profit in the second quarter of 2006 alone. In addition to requiring fines for each of the illegal policy cancellations you must require all HMOs and health insurers to adopt specific policy changes necessary to protect California patients.

The window-dressing reform Blue Cross issued on Monday following the latest exposé by the Los Angeles Times falls far short of Blue Cross's legal responsibilities and your commitment to enrollees. It is impossible to judge the proper response until regulators and Blue Cross make public the full extent and nature of the cancellations.

Canceling coverage is clearly prohibited in California unless an insurer or HMO can prove a patient's "willful misrepresentation" or "actual intent to deceive" the company about a past medical condition (Health & Safety Code § 1389.3 and Insurance Code §10384 & 10380). However, in the "retroactive rescission" complaints against Blue Cross, patients were terminated for health problems they did not have or did not know they had, and others for conditions that they clearly reported to Blue Cross.

Blue Cross and others argue that any omission in the enrollment form is a basis for denying a claim and canceling policies. Blue Cross and others have also said that insurers are allowed to conduct so-called "post-claim underwriting" if the insurer was unable to do an adequate pre-claim review because of a purported omission on the enrollment form. Both contentions are incorrect. California law requires insurers and HMOs to show that a purported omission on the enrollment form was not made inadvertently. Omissions that warrant a policy rescission must be shown to have been made with the intent to deceive. Secondly, the law requires an HMO or insurer to review a patient's medical records and resolve any questions about past medical conditions before granting coverage. Most patients have been not to medical school, and for that reason, California law requires insurers, not patients, to review and interpret medical records.

First and foremost, the public deserves to know how many policies were retroactively canceled. We know from court depositions that 1,500 policies were reviewed each week by Blue Cross's "retroactive review department" – that's almost 80,000 per year. How many were rescinded? One quarter? Half? How many were, like those complaints under review, revoked without cause?

Even as discussion of corrective action continues, you must, at a minimum, require Blue Cross to implement the following:

1. Dismantling of "Retroactive Rescission Departments"

State law clearly bars insurers from revoking coverage after a policy has been sold based on information in a patient's medical records or submitted on an enrollment application. Reviews of medical records must be reviewed prior to enrollment, not afterward. Yet, the so-called "retroactive rescission departments" at Blue Cross and other insurers are specifically designed to do just that. These departments must be dismantled immediately.

2. Independent Determination of "Willful Misrepresentation" and "Actual Intent to Deceive"

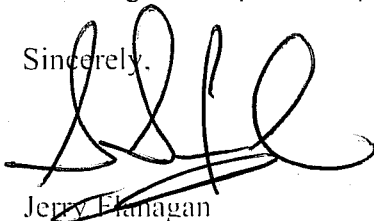
The key to determining if a retroactive cancellation is warranted is whether a patient intentionally meant to deceive an insurer. Neither Blue Cross, nor any other insurer, should be the arbiter of the patient's intent given the significant financial incentive for insurers to deny as many cases as possible. Therefore, independent state regulators must review each case before rescissions are carried out. The Department of Managed Health Care must also audit all rescissions completed to date and demand restitution and require penalties for each inappropriately canceled policy. Information about these rescissions must be made available to the public.

3. Issuance of Clear & Understandable Applications

Blue Cross's applications are designed to deceive and confuse patients. Double-speak and overly broad clauses in these forms trap patients who often do not know what information is in their medical records, and could neither understand it nor accurately report it if they did. The forms themselves appear to be part of a strategy to invoke an omission on the enrollment form by requesting information over such a long period and in such a broad detail that no patient could be expected to remember or report it. State law already requires enrollment forms to be clear and understandable. This fix is long overdue.

Even these preliminary policy changes cannot be deemed an adequate until all the facts are available. Knowing the scope of the problem is critical to determining the breadth of the reform necessary.

Sincerely,

A handwritten signature in black ink, appearing to read "Jerry Flanagan". The signature is stylized and cursive, with a horizontal line drawn across the bottom of the signature.

Jerry Flanagan

cc: California Insurance Commissioner John Garamendi