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Monday, November 13, 2006

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

**RE: Petition for New Regulations and Enforcement of Existing Law Protecting Patients From Widespread Illegal Cancellation of Coverage**

Dear Ms. Ehnes,

The Foundation for Taxpayer and Consumer Rights hereby petitions the Department of Managed Health Care ("Department") to enforce the law and adopt new regulations to end the widespread practices of illegal cancellations of HMO and health insurance policies and postclaim underwriting.

**I. Reason for Rulemaking and Enforcement Request**

New regulations and other actions are necessary because Blue Cross, Kaiser, Blue Shield, Health Net, PacifiCare and likely others are illegally revoking health care policies when patients get sick. The overwhelming evidence demonstrates a routine and flagrant violation of state law that bars insurance companies from canceling policies unless patients are shown to have made intentional misrepresentations. (Health and Safety Code (hereinafter "H&S") § 1389.3, quoted *infra*, page 3.).

Insurance companies and HMOs are preying on the 2 million to 3 million Californians currently enrolled in individual policies. The companies know those consumers have no employer to protect them and no ally when they are sick and need coverage the most. The companies also know that for many, legal action, including a lawsuit, is not a realistic remedy when facing large, unpaid medical bills.

According to testimony from a former Blue Cross employee, the company has designated a department to comb through applications looking for any excuse to cancel policies after claims are filed.<sup>1</sup> According to the testimony, Blue Cross reviewed 1,500 policies per week and did not

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<sup>1</sup> *Sick but Insured? Think Again*, The Los Angeles Times, September 17, 2006

attempt to determine whether any omissions were intentional, as the law requires. At that rate, Blue Cross alone conducts illegal post-claim underwriting of 80,000 policies per year.

## **II. Authority for Petition, Adoption of Regulations, and other Requested Actions**

The authority for this petition is Article 1, § 3 of the California Constitution, which guarantees the public the right to petition the government for redress of grievances. Additionally, this petition is submitted pursuant to §§ 11340.6 and 11340.7 of the California Government Code, which allows any person to request the adoption of regulations. Government Code § 11340.7 requires the Department to respond to this request for new regulations within 30 days.

H&S §§ 1341(c), 1341.8, 1341.10, 1357.17, and others require, you, as director of the Department of Managed Health Care, to exercise all powers necessary, including adopting regulations, to enforce the law:

The director shall be responsible for the performance of all duties, the exercise of all powers and jurisdiction, and the assumption and discharge of all responsibilities vested by law in the department. The director has and may exercise all powers necessary or convenient ...

(H&S § 1341(c).)

Among the Legislature's stated intent for the Knox-Keene Act, which governs managed care organizations and whose enforcement is the Department's duty, is:

Prosecuting malefactors who make fraudulent solicitations or who use deceptive methods, misrepresentations, or practices which are inimical to the general purpose of enabling a rational choice for the consumer public.

(H&S § 1342(c).)

There is no better example of a practice eliminating a "rational choice for the consumer public" than illegal retroactive rescissions of coverage that allow an HMO or insurer to advertise and sell a policy and then revoke it when a patient needs coverage the most.

### 1. Retroactive rescissions and postclaim underwriting

Insurers and HMOs are already required to make decisions about providing coverage based on a person's medical risk and to clarify any issues arising from the enrollment application *before* granting coverage. (H&S § 1389.3). Further, it is unlawful that the simple filing of a claim for care should trigger an underwriting review of insurance policies that patients have paid for and rely on. (H&S § 1389.3.)

The only provision of the law that allows HMOs and insurers to retroactively cancel coverage limits that action to instances when the company can show “willful misrepresentation” on the part of the patient. (H&S § 1389.3.)

“No health care service plan shall engage in the practice of postclaims underwriting. For purposes of this section, "postclaims underwriting" means the rescinding, canceling, or limiting of a plan contract due to the plan's failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the plan contract. This section shall not limit a plan's remedies upon a showing of willful misrepresentation.”

(H&S 1389.3.)

The limited right to rescind, upon a showing of “willful misrepresentation” (H&S § 1389.3), follows the narrow provisions for canceling or non-renewing an insurance policy, which also require a demonstration of the enrollee’s intentional bad faith. Specifically, § 1365 allows insurers and HMOs to only cancel policies for “failure to pay” or “for fraud or deception.” Under § 1357.54, an HMO or insurer can only refuse to renew under an equally narrow set of circumstances:

- i. An enrollee moves out of the service area;
- ii. The company ceases to provide insurance coverage;
- iii. An enrollee fails to pay the required premiums; or,
- iv. An enrollee commits fraud or is found to have made an “intentional misrepresentation of material fact.”

## 2. Investigate rescissions and require reinstatement of coverage

The Department is required to pursue reinstatement of insurance coverage for each person whose policy is illegally canceled. Reinstatement of coverage “shall be retroactive to the time of cancellation or failure to renew and the plan shall be liable for the expenses incurred by the subscriber.” (H&S § 1365(b).) Specifically, § 1365(b) provides:

An enrollee or subscriber who alleges that an enrollment or subscription has been canceled ... because of the enrollee's or subscriber's health status or requirements ... may request a review by the director. ... Within 15 days ... the plan shall either request a hearing or reinstate the enrollee or subscriber. ... A reinstatement pursuant to this subdivision shall be retroactive to the time of cancellation or failure to renew and the plan shall be liable for the expenses incurred by the subscriber or enrollee for covered health care services from the date of cancellation or nonrenewal to and including the date of reinstatement.

(H&S 1365(b).)

State law gives each policyholder the right to have their “grievances expeditiously reviewed.” (H&S § 1342). H&S § 1342 provides:

It is the intent and purpose of the Legislature to promote the delivery and the quality of health and medical care to the people of the State of California...by accomplishing all of the following: ... (h) Ensuring that subscribers and enrollees have their grievances expeditiously and thoroughly reviewed by the department.

(H&S § 1342.)

### 3. Clear and understandable applications

Unnecessarily complex and confusing health insurance application forms appear to be part of a managed health care strategy to induce an omission that can later be used as an excuse to cancel coverage. Section 1389.1(a) provides the director the authority to reject overly complex and ambiguous applications:

The director shall not approve any plan contract unless the director finds that the application conforms to both of the following requirements:

(1) All applications for coverage which include health-related questions shall contain clear and unambiguous questions designed to ascertain the health condition or history of the applicant.

(2) The application questions related to an applicant's health shall be based on medical information that is reasonable and necessary for medical underwriting purposes.

(1389.1(a).)

### 4. Require HMOs and health insurers to pay for approved treatments

State law also bars HMOs and insurers from refusing to pay doctors and hospitals once treatment has been approved. H&S § 1371.8 provides:

A health care service plan that authorizes a specific type of treatment by a provider shall not rescind or modify this authorization after the provider renders the health care service in good faith and pursuant to the authorization...

(H&S § 1371.8.)

However, the companies are ignoring the law and refusing to pay hospitals and doctors for treatments that were previously authorized. As a result, hospitals and doctors attempt to collect unpaid medical bills from patients whose coverage has been rescinded, forcing patients to file for bankruptcy.

## 5. Penalties and fines

Not only does the practice of illegal retroactive rescissions of health care demonstrate an utter disregard for statutes providing clear rules for rescissions, it is a violation of the requirements of Business and Professions Code § 17200 prohibiting “unlawful, unfair or fraudulent business acts and unfair, deceptive, untrue or misleading advertising.” The Department has been given specific authority by the Legislature to assess penalties against HMOs and health insurers licensed by the Department for violations of § 17200. (H&S § 1386(b)(7).)

In addition to penalties under Business and Professions Code § 17200, H&S § 1390 provides:

Any person who willfully violates any provision of this chapter or of any rule or order thereunder shall upon conviction be fined ... or imprisoned in the state prison, or in a county jail for not more than one year, or be punished by both such fine and imprisonment...

(H&S § 1390.)

Further, to enforce these and other provisions of the law, the legislature gave the Department power to suspend and revoke the licenses of non-complying companies and assess other penalties as necessary. (H&S § 1386(a) et seq.)

## **III. Regulations and Other Actions Requested**

This strategic targeting of California’s most vulnerable consumers – patients in the midst of treatment – requires timely and comprehensive action. The Foundation for Taxpayer and Consumer Rights, California’s leading non-partisan public interest advocacy organization, hereby petitions the Department to take the following actions:

### 1. Promulgate regulations reinforcing ban on illegal rescissions and postclaim underwriting

To uphold the law, given the significant financial incentive for insurers to deny as many cases as possible, the Department must initiate a rulemaking to provide that no insurer, HMO, subsidiary or contracted entity should be the final arbiter of whether a patient intentionally mislead the company. The statutory provisions requiring an insurer to provide a “showing of willful misrepresentation” (H&S § 1389.3) by the patient compels the Department to craft regulations to establish a process for such a showing. New regulations must require insurers and HMOs to prove a patient’s willful misrepresentation to regulators prior to rescinding coverage. (“This section shall not limit a plan’s remedies *upon showing* of willful misrepresentation”). (H&S § 1389.3).

Pursuant to § 1389.3, the department must promulgate new regulations:

- ✓ Requiring insurers and HMOs to affirmatively show a patient’s “willful

misrepresentation” prior to rescinding coverage.

- ✓ Barring insurers from conducting rescission reviews based on the filing of a claim.

Pursuant to § 11340.7 of the Government Code, the Foundation for Taxpayer and Consumer Rights expects a response to its rulemaking petition within 30 days.

## 2. Conduct full investigations of rescission complaints

The Department’s single action requiring Kaiser to reinstate coverage for one patient is manifestly inadequate to remedy an industry-wide practice. Section 1365(b), *supra*, provides that every patient deserves equal treatment.

Pursuant to § 1365(b), the Department must:

- ✓ Audit all rescissions completed to date and require restitution and reinstatement of coverage for each inappropriately canceled policy.
- ✓ Conduct annual audits of all licensees thereafter and make them available in public reports.

## 3. Require clear and unambiguous enrollment applications

Often complicated, technical and vague, the health insurance application forms are out of compliance with state law requiring clear, understandable applications. (H&S § 1389.1.) Patients should not be penalized for failing to report overly detailed or technical information about their medical histories that they may not have access to, or cannot be expected to understand.

Pursuant to § 1389.1(a), the Department must:

- ✓ Review all plans’ enrollment and renewal applications. Demand that they are clear and understandable and reject those that are not. Require that medical questions be specific and answerable by the applicant.
- ✓ Ensure that the information that an applicant is required to report is within the reasonable knowledge of a layperson.
- ✓ Require that all plans’ enrollment and renewal applications are made available for public inspection.

## 4. Promulgate regulations to remove financial incentives for illegal rescissions

Pursuant to § 1371.8, the Department must promulgate new regulations:

- ✓ To require HMOs and insurers to pay for services that they have authorized or otherwise

approved, and thereby remove a major financial incentive to rescind coverage.

Pursuant to § 11340.7 of the Government Code, the Foundation for Taxpayer and Consumer Rights expects a response to its rulemaking petition within 30 days.

5. Require penalties and fines for each illegal cancellation

The Department's \$200,000 fine levied against Blue Cross is far too little to deter the state's most profitable HMO from ending this lucrative anti-patient practice. Nor does the fine address violations by other licensees.

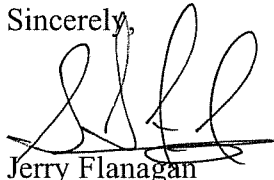
Pursuant to § 1390, the Department must:

- ✓ Require penalties, from fines to jail time, *for each* violation of the statute so that insurance companies, HMOs, insurers and their executives understand that they must keep the promises they make to enrollees.

If it is deemed that any of these cannot be implemented under existing statutory authority, the Department should immediately announce its intent to propose new legislation providing such authority when the legislature reconvenes in January as provided for under H&S § 1346(a)(1).

We look forward to discussing these recommendations with you and your staff.

Sincerely,



Jerry Flanagan

Health Care Policy Director

The Foundation for Taxpayer and Consumer Rights (FTCR)

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cc: Susan Kennedy, Chief of Staff, Office of Governor Arnold Schwarzenegger  
Sunne McPeak, Secretary, Business, Transportation and Housing