WHITE PAPER

Merger of the Department of Managed Health Care
Into the California Department of Insurance: A Policy Assessment

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Executive Summary

Changes in the delivery and financing of health care in California in the context of national reform require attention to the means and methods of regulation. The needs for regulatory clarity, efficiency, as well as patient-consumer protection must also be considered in the context of increasing pressures from a lagging economy. One critical aspect to evaluate is the desirability of a potential merger between the two California agencies that regulate health care: the California Department of Insurance (CDI) and the Department of Managed Health Care (DMHC).

Currently, CDI regulates traditional indemnity insurer arrangements while DMHC governs managed care health services plans.

Such assessment can be performed by considering issues relating to public accountability (elected versus appointed oversight), regulatory efficiency (duplicative oversight functions, consumer confusion, and regulatory conflict), consumer protection statutory powers (relevant oversight tools), provisions for coordination (intra-governmental collaboration), regulatory outcomes (prosecutions and fines), preemption concerns (federal law trumping state regulatory power), peer relationships (national regulatory collaborations), and national health care reform parameters.

Each of these areas on balance appear to support a merger of DMHC into CDI with CDI as lead agency.

Public accountability. The Insurance Commissioner is an elected official directly accountable to California citizens as a result of citizen initiation of Proposition 103, whereas the DMHC Director is a gubernatorially-appointed position. Public accountability hence appears to be more direct in a CDI-led organization. The political science literature supports an elected official for public accountability, with the latter often more successful in agency requests, budgets, and actions compared with political appointees, who are more beholden to Governor interests. Overall, a California Insurance Commissioner who is elected in conformance with popular enactment can generally act independently, and must directly address citizen interests for reelection, whereas leadership and decisionmaking at DMHC is insulated from citizen review and instead requires Governor Office support first.

Regulatory Efficiency. Overlap. There is considerable overlap between DMHC into CDI. Both have duplicative capital infrastructures as well as overlapping substantive public services such as Independent Medical Review. Further, similar regulatory authority over health care creates the need for resources dedicated to determining which entity has jurisdiction over any given dispute. Duplicative resources also extend to industry, where even when insurers have identical consumer applications and operate as a single business, they must determine which product is regulated by which entity, and provide separate filings to each agency.

Consumer Confusion and Regulatory Conflict. Importantly, this overlap results in consumer confusion regarding which agency is appropriate for complaints—which may delay and increase the costs of an injured patient’s access to appropriate treatment. Unfortunately, this consumer confusion extends logically when there are inconsistent holdings between the entities,
such as under review of Applied Behavioral Analysis (ABA) therapy, DMHC permits ABA to be shifted into an education category by plans and thus excluded, whereas CDI applies traditional insurance law principles and prohibits exclusions of ABA without clear and conspicuous indication in the contract. CDI principles appear to protect consumer to a greater degree than DMHC activities.

**Consumer Protection Statutory Powers.** This latter consumer protection rules and outcomes indicate CDI is the relevant agency to lead in consumer protection efforts. Further, however, CDI active statutory powers also indicate that the duplicative infrastructure and services of DMHC should be consolidated into CDI.

*Licensing and Requirements for Sellers.** CDI directly oversees licensing of insurance agents and has extensive requirements and penalties, whereas DMHC generally transfers mandates onto each individual health plan to “assure itself” of product solicitor knowledge. CDI also has greater powers to discipline errant agents, whereas DMHC generally takes no action. Hence, CDI direct regulation wields greater oversight and regulation of health care products.

**CDI Extended Jurisdictional Powers Over All Insurance Matters.** In addition, beyond powers both traditionally have for investigation and their potential violations, such as cooperating with Attorney General prosecutions and prosecuting other cases it brings, CDI has powers beyond DMHC. CDI has independent, first instance determination of jurisdiction over insurance matters, providing Insurance Commissioner authority to conduct independent investigatory hearings. This extends to considerable and broad subpoena power.

**CDI Claims Practice Regulation and Rate Reviews.** Further, CDI enforcement authority over insurer claims practices is much greater compared with DMHC, which has no analogous statute in this area, limiting itself to a 15% penalty provision for unpaid, uncontested claims. As well, rate reviews are also stronger with CDI, with both standards and penalties for rate setting and abuses. CDI coordinated enforcement also extends to a system of penalties and prosecutorial cooperation to prosecute insurance fraud, both civilly and criminally. DMHC has no history of actuarial rate review, no such provision for claims practice assessments, nor combined civil and criminal powers.

**Fraud Tools.** Importantly, oversight of anyone who is engaged in insurance fraud is under the auspice of CDI’s general jurisdiction, including those engaged in selling and providing insurance products without licenses. It has independent authority to prosecute these violations administratively. DMHC has a tremendous policy hole of being able to regulate *only its licensees.* Further, CDI may also bring general consumer protection lawsuits, whereas it is unclear if DMHC has such authority. Similarly, CDI has general anti-fraud laws that allow whistleblower participation in fraud detection and prosecution without any equivalent in DMHC.

**Legal Collaboration.**
This CDI collaboration with private lawsuits can be a source of funds for general coffers. Generally, CDI has unique flexibility in challenging fraudulent conduct that is not extant in DMHC.

Beyond working with the private sector in lawsuits, however, CDI also cooperates in prosecution efforts with local law enforcement for additional efficiencies. These extend to all county District Attorneys. DMHC has limited collaboration, and has in fact engaged in litigation with insurers.
against other entities such as the Los Angeles City Attorney, who was bringing California consumer protection lawsuits against insurers engaged in illegal rescission. Further supporting cooperation, CDI has significant experience and history in civil and criminal prosecutions and demonstrated success in fraud recoveries. CDI also has a standing investigations audit unit to assist in these efforts. CDI publishes this information and its recoveries publicly for accountability purposes.

DMHC, in contrast, rarely initiates administrative or civil litigation nor prosecutes through hearing or trial. Its low volume and limited public data (available from only 2005 and before) shows only letters of agreement or settlement agreements as its outcomes. DMHC acknowledges its prosecutorial limitations in this area. Empirically, DMHC has also has limited success in its settlements, as recent insurer rescission settlements garnered single digit participation rates by victims. Hence, actual regulatory authority and transparent outcomes indicate greater potential accountability and recoveries using CDI powers compared with DMHC.

**Preemption by Federal Law.**
Federal law, including healthcare reform, has raised important concerns about state law preemption and federal-state collaboration. Preemption considerations indicate CDI may be best as a lead agency with DMHC merged within it. For example, all Medicare Advantage plans are governed exclusively by federal law, with the exception of state licensing laws and state solvency laws. This effectively preempts DMHC authority, since it does not license agent or broker conduct, while CDI authority is preserved by its licensing authority to engage in direct consumer protection activities. Indeed, its consumer protection authority in solvency is more stringent than DMHC’s, as DMHC recognizes, further providing protections to consumers. Hence, only under CDI authority can consumer protection of errant health product sales be substantively continued.

**National Healthcare Reform.**
As well, the recent federal Patient Protection and Affordable Care Act (ACA), healthcare reform bill expressly notes and contemplates significant implementation input from state Insurance Commissioners through the National Association of Insurance Commissioners (NAIC). NAIC is the key entity that will set standards for health care reform implementation in the states and hence is a key policymaking body. CDI and DMHC fractionation of activity creates vacuums of input and authority into NAIC, since DMHC is not a member of NAIC. Merging DMHC into CDI would allow unified professional knowledge and approaches to express the needs and realities of California in any federal health care reform effort.

**Conclusion.**
Overall, it appears that on balance, a merger of DMHC into CDI will create efficiencies in operations and promote consumer protection activities. Further, it can ensure continued state oversight and a unified California perspective under federal health care reform.
WHITE PAPER

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Bryan A. Liang, MD, PhD, JD*

I. Introduction

California is the only state in the nation that has a dual regulatory structure for licensing, regulating and overseeing health insurance and related products through the California Department of Insurance (CDI) and the California Department of Managed Health Care (DMHC). Because of this atypical dual structure, there may be challenges with ensuring consumer protection and consistent regulatory efforts and decisions.

To assess these concerns and the desirability of a merger of DMHC and CDI, this White Paper reviews CDI-DMHC policy issues of public accountability, regulatory efficiency and cost savings, revenue generating potential, investigative and prosecutorial powers and effectiveness and regulatory oversight experience.

II. Public Accountability

A. Elected Official versus Gubernatorial Appointee

California utilizes two different approaches to regulate health care: an elected official leading CDI, versus a gubernatorial appointee for DMHC. It appears that use of a single, elected official may provide greater efficiency and stability for consumer protection, compared with a relatively insulated gubernatorially appointed person.

In California, elected officials provide important reification for voter preferences. The importance attached by California’s voters to public scrutiny of, and participation in, the regulation of insurance is illustrated by their approval in November 1988 of an initiative instituting controls on property-casualty insurance through a transparent and responsive regulatory process. California Proposition 103 then placed control of that regulatory process in an Insurance Commissioner, who was required to be elected, commencing in November 1990. Indeed, research has indicated the desirability of this development:

Entrusting the responsibility to implement Proposition 103 to an elected official had several virtues. An elected commissioner is subject to public, rather than political, supervision: only the voters may pass judgment on the commissioner’s performance,

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providing the commissioner with the independence and incentive necessary to establish good public policy. A commissioner who fails to protect the public will not be re-elected to office. This will protect against efforts by insurance companies to install their own candidate for the job. … Appointment does make the commissioner more beholden to the Governor than to the people. Since it therefore takes two people (the governor and the commissioner) to be politically willing to stand up to the powerful insurance lobby, the election process offers a somewhat better opportunity for consumer interests to be fairly represented.¹

Moreover, other research has noted that appointed officials will likely place Governors’ agendas and approaches first as a loyalty matter:

Governors likely expect loyalty from their own appointed officials; appointees may have to shape their budget requests in line with the governor's policies. In conflicts, appointed heads may be less able to defend themselves from executive cuts. Elected officials, not beholden to the governor, may operate with different agendas.²

In addition, it appears that an independent, elected official also obtains more gubernatorial office attention compared to appointed ones. Indeed, empirical analysis shows that elected officials do much better than appointees with agency requests when dealing with the Governor’s Office.³ This is consistent with earlier political science literature that suggests that states with elected officials are more independent and alter gubernatorial budget recommendations more than appointed ones.⁴

The political science literature also notes that appointed officials have not been as effective in garnering state funds for their activities. Hence, it has been observed that appointed officials generally request much higher budgetary amounts, indeed, much higher than historically obtained or justified.⁵ This is an artificial means of increasing budgets that is based more on political expediency than substantive need, and further supports the use of an elected official.

B. Accountability and Transparency in Structure and Decision Making

There is hence significant potential for an elected CDI Insurance Commissioner to be more effective than an appointed DMHC director. As well, such an approach appears to be consistent with voter initiatives. However, in addition, both transparency of decision making and accountability for those decisions would likely be heightened by placing jurisdiction over all health care products under an elected Insurance Commissioner directly answerable to the polity.

Importantly, a single, elected Insurance Commissioner is of enormous advantage at the present time. Modifications in the insurance industry will be required by the federal health care

³ Id. at 157.
⁴ See, e.g, Ira Sharkansky, Agency Requests, Gubernatorial Support, and Budget Success in State Legislatures. 26 AM. POL. SCI. REV. 1220 (1968); and IRA SHARKANSKY, THE POLITICS OF TAXING AND SPENDING (1969).
⁵ Thompson & Felts, supra at 157.
reform legislation, which will require needed input by patients—the consumers of healthcare. This emphasizes the need for an elected Commissioner who is directly accountable to the public.

Further, since only the voters may pass judgment on the Commissioner's performance, the Commissioner has the independence, as well as the incentive, necessary to act and decide matters in the public interest. Because voters will evaluate the Insurance Commissioner by the fairness of the rates and practices of insurers, a Commissioner who fails to satisfy the public would find it difficult to win re-election. 6

However, in contrast to the accountability and transparency of an elected Insurance Commissioner, the structure of DMHC is not easily determined and bureaucratic. It is among the smaller California Departments housed within the Business, Transportation and Housing Agency (“Agency”). However, this placement is not for efficiency or other substantive purpose; instead, the arrangement simply appears to be a random amalgam of independent agencies without any unifying regulatory themes. For example, the Agency’s portfolio is one of the state’s most diverse containing 14 departments, including the California Department of Transportation, Highway Patrol; Departments of Motor Vehicles, Financial Institutions, Housing and Community Development, Corporations and Real Estate; the Housing Finance Agency; and the Office of Traffic Safety. It addresses a myriad of issues including transportation, public safety, affordable housing, international trade, financial services, and tourism, as well as managed health care.

In addition, leadership and decision making within DMHC are also of concern from a polity and consumer focus perspective. DMHC’s executive officers report directly to the Agency Secretary and ultimately to the Governor, rather than directly to the public. Further, DMHC officials may not act independently, but require Agency and Governor’s Office approvals of any DMHC action, using processes that are not public. This diversion of mission and accountability in DMHC can be improved using a single agency with an elected Insurance Commissioner.

California is not the first to elect its Insurance Commissioner. Eleven states currently elect their Insurance Commissioners. The substantive reason for this approach is that stronger consumer protections appear to exist in the states with elected, as opposed to appointed, insurance commissioners. 7 Hence, given this experience, having an elected official responsible for oversight of the insurance industry appears important to allow him or her to be independent and more strongly supportive of consumers and committed to consumer protection. Legally, as well, in California statutory tools are more focused in CDI, providing powers and regulatory efficiency to monitor insurance company practices that are greater than DMHC’s.

III. Regulatory Efficiency

A. Duplicative Regulation: Structure

1. General Duplication

It is axiomatic that duplicative regulation is inefficient and wasteful. Elimination of such regulatory redundancy is sought at every level of government in virtually all nations. This is particularly important during the challenges of a poor economy and state deficits.

As a matter of form, the simple structure of two departments that regulate similar matters creates inefficiencies. For example, the dual CDI-DMHC regulatory scheme has significant duplication of structures and functions. Both departments have websites, stationery, direct and indirect labor costs, IT functions, and capital costs as well as other facets that must be underwritten. Further, as a matter of substance, CDI and DMHC have offices and personnel that address health care consumer services and protection, independent medical review, solvency, fraud prevention, legislative activities, communications with the public, legal services, rate review, and administration. This duplication of structures and functions results in unnecessarily increased costs to government and the polity.

2. Jurisdictional Inefficiency

But further, the issue of duplicative regulation is significant in that not only do the two agencies have regulatory authority over similar products, there are inefficiencies between CDI and DMHC as to basic questions such as which agency has jurisdiction over a particular case. This split is confusing and highly costly as a regulatory efficiency matter and from a public citizen viewpoint.

For example, CDI and DMHC have dual regulatory jurisdiction over similar health care insurance and coverage products in two agencies. The split in regulatory authority requires personnel in both to enter the costly and inefficient process of first gathering sufficient information to determine whether it has jurisdiction. This is a completely duplicative step that would be avoided by a single agency with authority over health care insurance products.

From the patient-consumer perspective, this inefficiency has direct adverse effects. Perhaps this is most profoundly illustrated by the thousands of complaints that are wrongly filed which must be transferred by one regulator to the other each year. Of course, there will then be a re-review of the consumer’s complaint by the other department, resulting in delay for the ill or injured patient-consumer. This imposition of

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9 See Section III.C below (discussing details on erroneous complaints that must be transferred between CDI and DMHC).
duplicative and unnecessary additional efforts, time, and expense for a patient-consumer complaint, which does nothing on a substantive level and only determines jurisdiction, could be avoided if all functions were consolidated under one agency.

B. Duplicative Regulation: Industry Impact

Duplicative regulation clearly increases costs to the state and to the patient-consumer. But in addition, dual regulatory jurisdiction also adds unnecessarily to the inefficiency, complexity and costs of doing business for regulated entities. Insurance companies treat their products as a single business, doing the same underwriting, and using the same computer systems, the same complaint handling processes, and the same personnel. Yet in California, they may be subject to different agency jurisdictions, offices, and infrastructures, creating additional costs for them and, ultimately, for patients-consumers, compared with all other states that house health product regulatory oversight within a single Department of Insurance.

For example, WellPoint Inc., a publicly traded Indiana corporation, describes itself and its subsidiaries in its most recent Form 10-K filed with the Securities and Exchange Commission as a single health benefits company, thereby acknowledging that its products comprise a single business. But some of the WellPoint subsidiaries’ products are regulated by CDI while others are regulated by DMHC. WellPoint’s subsidiaries include Anthem Blue Cross, which is regulated by the DMHC, and Anthem Blue Cross Life and Health Insurance Company, which is subject to CDI’s regulatory authority.

Yet both subsidiaries have executive offices at the same location. Both use the identical application form for their individual and family plan coverage, whether that coverage is health insurance regulated by CDI or a health care service plan regulated by DMHC. And, to show that this dual regulatory structure is not substantively different from the insurer’s perspective, Blue Cross Life has few, if any, employees of its own, but instead uses administrative agreements with Anthem Blue Cross to perform all of its business functions, including marketing, underwriting, and claims adjustment. Thus, in very significant ways, these subsidiaries operate as a single company, just as WellPoint reports to the Securities and Exchange Commission. But health benefit companies like WellPoint must divide their activities into a unique, dual artificial framework in the state of California. At a minimum, this regulatory structure leads to inefficiency, requires businesses to have duplicative staff, and raises the cost of health care coverage to California citizens due to passed on costs.

C. Duplicative Regulation: Consumer Confusion

Beyond inefficiency concerns that arise from duplicative regulation and the impact on state coffers, patient-consumer protection, and industry, another key impact is the confusion amongst the polity generally: consumers, health advocates, legislators and members of the public. The dual regulatory structure creates a distinction without a substantive difference to the citizen. From the consumer’s perspective, there is little difference legally or practically between health care service plans and insurance policies. Indeed, a California Court of Appeal also has concluded similarly, noting:

HMO’s or health care service plans …are engaged in providing a service that is a substitute for what previously constituted health insurance. The only distinction between
an HMO …and a traditional insurer is that the HMO provides medical services directly, while a traditional insurer does so indirectly by paying for the service, but this is a distinction without a difference. In the end, HMOs function the same way as a traditional health insurer. The policyholder pays a fee for a promise of medical services in the event he should need them….

The research literature also reports longstanding confusion between, specifically, DMHC and CDI. For example, Professor J. Clark Kelso, in his 2001 study, noted: “There seems to be general agreement that consumers and others are often confused about the identity of the appropriate [health plan] regulator under current law.” Further, the California Healthcare Foundation noted that healthcare stakeholder impressions included:

**Current System Is Confusing to Consumers.** Since the department of jurisdiction for different health insurance products is based in part on history and legal technicalities, the differences are invisible or too complex for consumers to recognize. As a result, the dual regulatory system is difficult for consumers to navigate when they have problems with health care.

Such confusion has real, substantive impacts. It impairs the ability of patient-consumers to effectively report abusive practices or obtain redress. It also prevents the agencies from obtaining all necessary information to take strong, timely and effective enforcement action.

This confusion is not simply a theoretical concern. The fact consumers are confused by the existence of jurisdiction in an agency other than CDI is demonstrated each year by the many consumers who have contacted CDI that must be referred to DMHC. Professor Kelso reported 5,500 such referrals in 2001, and the confusion continues to exist. The following table contains the numbers of consumer calls to the CDI hotline which were referred to DMHC between 2006 and 2010:

<table>
<thead>
<tr>
<th>Year</th>
<th>Number Referred by CDI to DMHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>5,500</td>
</tr>
<tr>
<td>2006</td>
<td>4,118</td>
</tr>
<tr>
<td>2007</td>
<td>3,977</td>
</tr>
<tr>
<td>2008</td>
<td>3,367</td>
</tr>
<tr>
<td>2009</td>
<td>2,758</td>
</tr>
<tr>
<td>2010</td>
<td>2,589</td>
</tr>
</tbody>
</table>

Source: California Department of Insurance.

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11 J. Clark Kelso, Regulatory Jurisdiction Over Health Insurance Products: The Department of Managed Health Care & The Department of Insurance 3 (2001).

12 Debra L. Roth & Deborah Reidy Kelch, California Healthcare Foundation: Making Sense of Managed Care in California 13 (2001). The California Healthcare Foundation report noted that a partial reason for this is because of the similarity in the products they regulate: “Over time, the differences between these two models [of indemnity and prepaid managed care] have been obscured or blurred for many observers and stakeholders.” See id. at 12.
Similarly, consumer confusion is also apparent from the number of written complaints to CDI that have been referred to DMHC because the complaints involve products under DMHC’s jurisdiction:

<table>
<thead>
<tr>
<th>Year</th>
<th>Number Referred by CDI to DMHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>225</td>
</tr>
<tr>
<td>2008</td>
<td>161</td>
</tr>
<tr>
<td>2009</td>
<td>232</td>
</tr>
<tr>
<td>2010</td>
<td>286</td>
</tr>
</tbody>
</table>

Source: California Department of Insurance.

Hotline referrals have decreased somewhat because both CDI and DMHC have worked diligently to increase consumer awareness of the existence and jurisdiction of DMHC, collaborating closely at outreach events, improving web site information, and obtaining a reduction in calls referred over time. Yet written complaint confusion by consumers is still clearly a concern, and they still continue to believe their health care coverage is insurance, hence incorrectly contacting CDI with issues and complaints. For individuals who are coping with illness, and having difficulty in obtaining treatment or payment for it, adding another layer of reporting to a different department may impose a hardship and lead some to become discouraged and fail to pursue their remedies.

The identified overlaps in effort, patient-consumer confusion, and potential patient-consumer hardship could be avoided with a single agency.

**D. Duplicative Regulation: Inconsistent and Contradictory Requirements**

The impacts of duplicative regulation on costs, industry, and patient-consumers are substantive. Simply having two agencies performing highly similar tasks over similar markets and services is redundant and inefficient. This alone would be cause for considering merging them. But further, when these duplicative authorities conflict, there is a strong imperative to formulate policy to address this as a pressing, high priority matter. This is currently the situation in California.

Dual jurisdiction has resulted in contrary and inconsistent guidance to regulated entities, differences in coverage of treatment for patients, and increased public expenditures. A key and important example is the treatment of Applied Behavioral Analysis therapy (“ABA”). CDI and DMHC differ significantly in the way they handle requests for ABA therapy for children with autism.

DMHC has permitted plans to refuse to pay for ABA when it is provided in the customary, cost effective way by utilizing graduate students under the supervision of licensed providers. After a series of 15 out of 16 cases in which plan denials of ABA as experimental/investigational were overturned by Independent Medical Review (“IMR”) on the grounds that such treatment had become the standard of care for children with autism, the plans asserted a new argument. They began claiming that ABA is not health care at all, but instead is education, and therefore argue that it is excluded from coverage, despite the lack of any such exclusion in the contractual documents.
Rather than follow well established California insurance law requiring that exclusions from coverage in health and disability policies must be clearly and conspicuously contained in the contracts, and construing those contracts against the drafter,\textsuperscript{13} instead, DMHC currently permits plans to deny treatment on that ground, and now defines “health care services” as only those which are actually performed by licensed providers, rather than under the supervision of licensed providers. In so doing, DMHC has allowed plans to deny coverage when services are not to be provided by the licensed providers themselves.\textsuperscript{14}

Under this DMHC rubric, plans have shifted many of the costs of ABA treatment to the state and its taxpayers, which fund such treatments through California’s regional centers.\textsuperscript{15} Yet this DMHC policy is contrary to the intent of the legislature, expressed in passage of the Mental Health Parity Act. It was the specific intent of that Act to shift away from taxpayers costs which should properly be borne by health care plans and insurers.\textsuperscript{16} This has been emphasized by recent Court of Appeals holdings.\textsuperscript{17}

CDI, by contrast, does not permit insurers to evade contractual responsibilities or shift them to California taxpayers. Instead, CDI views ABA as a disputed health care service. If any portion of the reason for the denial relates to medical necessity, or the purported experimental, investigational nature of the services at issue, CDI sends those matters for IMR. In 2010, at least ten such denials were overturned in IMR, with reviewers finding that ABA “is the best-known and best-researched therapy for patients with autism”, “has been in existence for at least 30 years and has been widely used in the therapeutic intervention in autistic children”, “is considered ‘state of the art’, and “is widely accepted as an effective treatment modality for young autistic patients and is consistent with the recommendations from the American Academy of Neurology.”

There is no sound or defensible policy reason for the granting or withholding of treatment dependent upon which regulator oversees the family’s health care coverage. Therefore, one agency should be responsible for decision making to ensure complete and consistent

\textsuperscript{13} See e.g., Haynes v. Farmers Insurance Exchange (2004) 32 Cal.4th 1198.
\textsuperscript{14} See March 9, 2009 letter to Licensed Full Service Health Plans and Specialized Mental Health Care Service Plans from Richard D. Martin, Deputy Director, Department of Managed Health Care, available at http://www.dmhc.ca.gov/library/reports/news/Improving_Plan_Performance.pdf.
\textsuperscript{15} These 21 centers throughout California contract with the Department of Developmental Services to provide or coordinate services for children with developmental disabilities pursuant to Gov. Code §95014.
\textsuperscript{17} See, e.g., Arce v. Kaiser Foundation Health Plan, (2010) 181 Cal. App. 4\textsuperscript{th}, 471, involving Kaiser's denial of ABA therapy to an autistic child:

In enacting the Mental Health Parity Act, the Legislature expressly found that “[m]ost private health insurance policies provide coverage for mental illness at levels far below coverage for other physical illnesses,” and that “[l]imitations in coverage for mental illness in private insurance policies have resulted in inadequate treatment for persons with these illnesses.” (Stats. 1999, ch. 534, §1.) The Legislature further found that “[t]he failure to provide adequate coverage for mental illnesses in private health insurance policies has resulted in significant increased expenditures for state and local governments.” (Stats. 1999, ch. 534, §1.) The stated purpose of the statute was to “prohibit discrimination against people with biologically-based mental illnesses, dispel artificial and scientifically unsound distinctions between mental and physical illnesses, and require equitable mental health coverage among all health plans and insurers to prevent adverse risk selection by health plans and insurers.”
policymaking. From the perspective of an evaluative task, it appears that CDI has a better record and approach in protecting consumers and ensuring healthcare services are provided.

IV. Statutory Powers

A. Investigative and Prosecutorial Tools

The inefficiency of two agencies addressing virtually identical issues and its adverse impact on state finances, consumer protection, regulations, and, particularly, policy consistency, raises the possibility that efficiencies could be realized by merging them. A substantive question is which agency will be merged into the other. Beyond accountability and transparency considerations of an elected versus appointed official, an assessment of the more inclusive policy powers of investigation and prosecution is needed to determine who should be the lead agency.

In this case, it appears that merging DMHC into CDI could increase protection for consumers, with regard to licensing, investigation and prosecutorial functions, as well as provide potential benefits for governmental revenues.

1. Broker/Agent Licensing and Oversight

The Insurance Code has a comprehensive set of requirements that individuals must meet in order to obtain and maintain licensure as insurance agents or brokers.\(^18\) The code sets forth stringent prelicensing education requirements for brokers and agents.\(^19\) The Code further enumerates an expansive list of grounds for denying licenses,\(^20\) and also contains extensive grounds for cause to suspend or revoke a permanent license.\(^21\) Finally, there is a separate chapter on disciplinary actions, designed to protect the public by requiring and maintaining professional standards of conduct on the part of all licensees\(^22\) and empowering the Commissioner to revoke or suspend licenses, based on the same expansive criteria as those which justify denial.\(^23\)

DMHC, in contrast, has no analogous educational, examination or licensure requirements to protect the public. It does not license individuals who sell products which it regulates, but

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\(^{18}\)See e.g., Ins. Code §1652, providing that applicants may be required to provide fingerprints and to disclose convictions and license discipline, and apply under penalty of perjury; and id. §1669, giving CDI authority to summarily deny an application or revoke a license if someone has a felony conviction or if a license has been denied/revoked/suspended in the last five years.

\(^{19}\)See Ins. Code §1749, which provides that 40 hours of classroom study are needed for a fire and casualty broker-agent license, with the curriculum approved by the Commissioner; 20 such hours are required for a personal lines broker-agent license, and 40 hrs for a life agent; 12 hours of study of ethics and the Insurance code; and, with only a few exceptions, requires passing a qualifying examination in order to obtain licensure. See, e.g., Ins. Code §1676.

\(^{20}\)See Ins. Code §1668, specifying the following grounds, among others: that granting a license would be against the public interest; that the applicant is not properly qualified; does not intend actively and in good faith to carry on as a business with the public; is not of good business reputation; is lacking in integrity; has been refused a professional, occupational or vocational license or had one suspended or revoked for reasons that should preclude granting a license; seeks to avoid or prevent operation or enforcement of California insurance laws; has knowingly made a misstatement in an application; or has previously engaged in a fraudulent practice or act or has conducted any business in a dishonest manner.

\(^{21}\)In addition to those enumerated in Ins. Code §1668, §1668.1 contains additional grounds, including a number of kinds of self dealing such as inducing a client, directly or indirectly, to cosign or make a loan, investment, gift to the licensee; or to make the licensee or his or her domestic partner or relative a beneficiary, or trustee.

\(^{22}\)See Ins. Code §1737.

\(^{23}\)Including Ins. Code §1668; see also Ins. Code §1738 et seq.
merely requires plans to list “solicitors” with whom it has contracted and provide a copy of the agreement (for example under Health & Safety Code §1351(i)). Although the Health and Safety Code\textsuperscript{24} gives the DMHC Director the power to set standards regarding training, experience or other qualifications necessary and appropriate in the public interest or for the protection of subscribers, enrollees, and plans, and to require that solicitors pass examinations, that power has not been exercised. Indeed, DMHC has promulgated no such requirements for training, experience, qualifications or examination of agents selling DMHC-regulated health plans, and does not review for prior license revocation, or dishonest or fraudulent acts. The only regulation implementing that statute provides, in full:

Prior to allowing any person to engage in acts of solicitation on its behalf, each plan shall reasonably assure itself that such person has sufficient knowledge of its organization, procedures, plan contracts, and the provisions of the Act and these rules to do so lawfully.\textsuperscript{25}

Thus, the DMHC generally takes no responsibility for broker or agent business qualifications or personal character.

Even if DMHC chose to exercise the statutory power to censure, suspend or bar a person from operating as a solicitor, the grounds for disciplinary action set forth in Health and Safety Code\textsuperscript{26} are more limited than those available to CDI, which is permitted to discipline on a host of grounds, including continued operation in a manner that may constitute a substantial risk to a plan or subscribers or enrollees; violation or attempt to violate, or conspiracy to violate any provision of this chapter, any rule, regulation or order adopted pursuant to this chapter; any conduct that constitutes fraud or dishonest dealing or unfair competition, as defined by Section 17200 of the Business and Professions Code, or conviction or nolo contendere plea to a crime substantially related to the qualifications, functions or duties of a person engaged in business in accordance with this chapter. However, as noted, DMHC generally has not taken action for brokers or agents.

\section{2. Investigative Tools}

Both CDI and DMHC have investigative powers under the Government Code. Section 11180 provides that the head of each department may make investigations and prosecute actions concerning:

(a) all matters relating to the business activities and subjects under the jurisdiction of the department;
(b) violations of any law or rule or order of the department; and
(c) such other matters as may be provided by law.\textsuperscript{27}

At the request of a prosecuting attorney or the Attorney General, any department may assist in conducting an investigation of any unlawful activity that involves matters within or reasonably related to the jurisdiction of the department.\textsuperscript{28} Under the Government Code, both the

\textsuperscript{24} Health & Safety Code §1359.
\textsuperscript{25} 28 Cal. Code Reg. §1300.59.
\textsuperscript{26} Health & Safety Code §1388; Ins, Code § 1738.
\textsuperscript{27} Gov. Code §11180.
\textsuperscript{28} Gov. Code §11180.5
Commissioner and the DMHC Director have the power, in connection with any investigation or action, to inspect and copy books and records, hear complaints, administer oaths, certify to all official acts, issue subpoenas for the attendance of witnesses and the production of writings and material things, promulgate interrogatories, divulge information to other prosecuting agencies, and present information from investigation of unlawful activity to a court or administrative hearing.\textsuperscript{29} Each Department also has the power to discipline by fines and penalties.\textsuperscript{30}

However, CDI has additional powers, above and beyond those applicable to DMHC. The Insurance Code\textsuperscript{31} requires insurance producers transacting insurance in California to be licensed by the Commissioner. As part of the licensing process, background checks are conducted on license applicants. Pursuant to California Code of Regulations,\textsuperscript{32} producers are required to maintain records of insurance transactions and to make those records available for review by the Commissioner or his designee upon reasonable request.

The Insurance Code also authorizes the Insurance Commissioner to investigate complaints against insurers, prosecute insurers, and assess fines and penalties.\textsuperscript{33} Significantly, the Commissioner has the ability to determine in the first instance “whether a given controversy falls within the statutory grant of jurisdiction.”\textsuperscript{34} This holding has empowered past Commissioners to use this grant to conduct investigatory hearings.

Further, the Commissioner has investigative prerogatives, including the power to issue subpoenas and subpoenas\textit{duces tecum} for witnesses to attend, testify and produce documents before him, on any subject touching insurance business, or in aid of his duties.\textsuperscript{35} These investigatory powers extend beyond insurers, and include agents brokers, as well as administrators.

These expanded powers of CDI compared with DMHC indicate that CDI may be the preferred lead agency in any merged department when considering patient-consumer protection.

\textbf{3. Prosecutorial Tools}

Regulating health care requires important powers of prosecution to deter inappropriate actions by insurers and promote the best interests of patient-consumers. Hence, this is a key area to assess in any merger considerations. Three stakeholder groups in this prosecutorial context are assessed: 1. Insurer Claims Practices, Rate Reviews, Fraud; 2. Producers; and 3. Others participating in the insurance business in some fashion.

\textbf{a. Insurer Claims Practices, Rate Reviews, Fraud}

\textbf{i. Claims Practices}

CDI differs from DMHC with regard to regulating and prosecuting claims handling. CDI

\textsuperscript{29} Gov. Code §11181.
\textsuperscript{30} Health & Safety Code § 1386; Ins. Code § 12926.1.
\textsuperscript{31} Ins. Code §1631; \textit{see also} Ins. Code §700.
\textsuperscript{32} \textit{See} 10 Cal. Code. Reg. §2190 \textit{et seq.}
\textsuperscript{33} \textit{See} Ins. Code §§12921.1, 12921.3.
\textsuperscript{34} \textit{See United States v. Superior Court} (1941) 19 Cal.2d 189, 195.
\textsuperscript{35} \textit{See} Ins. Code §12924(a).
has broad enforcement authority pursuant to California Insurance Code\textsuperscript{36} over the conduct of the insurance business in the state of California. Insurer claims practices are regulated by the Department’s Fair Claims Settlement Practice Regulations\textsuperscript{37} and Insurance Code provisions, including the Unfair Practices Act,\textsuperscript{38} prohibited acts,\textsuperscript{39} and other acts not defined in the statute,\textsuperscript{40} and are prosecuted as orders to show cause and/or cease and desist orders before the office of Administrative Hearings.\textsuperscript{41} The Insurance Code further sets significant graduated penalties with increased sanctions for willful behavior, including potential revocation of a Certificate of Authority to engage in insurance within the state.\textsuperscript{42}

In comparison to the extensive approaches regulating insurers, DMHC has no analogous statute addressing unfair claims practices. Instead, there is a provision that failure to reimburse an uncontested claim within the statutory time frame accrues interest at the rate of 15% a year.\textsuperscript{43}

\textbf{ii. Rate Reviews}

Rate reviews for insurance products are regulated generally by CDI under Proposition 103, which provided for prior rate approval, and is codified in the Insurance Code.\textsuperscript{44} Insurers file proposed rates with CDI, which then must be reviewed under standards within the Insurance Code and, if disapproved, that decision must be provided within 180 days.\textsuperscript{45} If disapproved, a “Notice of Non Compliance” is issued and the insurer can request a hearing.\textsuperscript{46} Penalties for failure to comply with the Commissioner’s order are not to exceed $50,000 per violation or willful failure up to $250,000, up to and including revocation of a Certificate of Authority.\textsuperscript{47} These skills enable CDI to identify flaws in requests for increases in premiums for health insurance, and successfully negotiate reductions in or withdrawal of those requests, as described subsequently in Part IV.H, even in the absence of authority to reject requests for premium increases as excessive.

No comparable provisions exist in DMHC’s statutory scheme and it has no history of actuarial rate review.

\textbf{iii. Fraud}

Fraud is expensive and cheats the state and the patient-consumer from the benefits of health care insurance and increases costs. Hence, it is imperative that beyond statutory powers to assess and regulate, there be appropriate specific penalties for such illegal activities and a

\begin{itemize}
\item \textsuperscript{36} Ins. Code §12921.
\item \textsuperscript{37} See 10 Cal. Code Reg. §2695, \textit{et. seq}.
\item \textsuperscript{38} See Ins. Code §790 \textit{et seq.} (containing provisions of Unfair Practices Act).
\item \textsuperscript{39} See Ins. Code §8790.03 (outlining prohibited acts).
\item \textsuperscript{40} Ins. Code §790.06 (outlining additional actions subject to Unfair Practices Act not defined in §790.03).
\item \textsuperscript{41} See Ins. Code §790.05.
\item \textsuperscript{42} See Ins. Code §790.035 (setting penalties for violation of California Ins. Code §790.03: $5,000 per violation, $10,000 if willful. Ins. Code §790.07 sets forth penalties for violation of Ins. Code §790.06; $5,000 per violation, $55,000 if willful, and sanctions for further violation of a cease and desist order up to and including revocation of a Certificate of Authority).
\item \textsuperscript{43} See Health & Safety Code §1371.
\item \textsuperscript{44} See Ins. Code §1861.01-05.
\item \textsuperscript{45} Standards for approval are set forth in Ins. Code §1861.05 and in the rating factors in 10 Cal. Code Reg. §2641.1, \textit{et seq}.
\item \textsuperscript{46} Hearings are conducted pursuant to Ins. Code §§1861.055 and 1861.08.
\item \textsuperscript{47} See Ins. Code §§1859.1, 1861.4.
\end{itemize}
coordinated system between regulators and prosecutors to prosecute fraud.

For CDI, the Insurance Frauds Prevention Act defines such a system of penalties and prosecutorial cooperation. The statute provides for penalties for fraudulent activities including imprisonment in the county jail for one year, or in the state prison for two, three, or five years, or by a fine not exceeding one hundred fifty thousand dollars or double the amount of the fraud, whichever is greater, and restitution. The Insurance Code also specifically permits the Insurance Commissioner to certify the facts of any legal violation to the District attorney of the county in which the offense occurred for prosecution.

No such provision or penalty exists for DMHC in this fraud arena.

b. Producers.

Regulation of those who sell or engage in insurance practice within the state must be stringent. Producers, which are defined as agents, brokers, bail agents, adjusters, administrators, and others, under CDI are required to be licensed pursuant to various portions of the Insurance Code. As a condition of licensure, these individuals agree to submit to the disciplinary jurisdiction of the Insurance Commissioner. Non-criminal violations of the Insurance Code are handled administratively. Administrative proceedings can result in revocation or suspension of a producer’s license, revocation and issuance of a restricted license, or fines. In addition, the Insurance Code provides for the immediate removal or suspension from office or employment with a production agency if the subject person has engaged in misconduct with respect to the business of insurance or fraud, or is otherwise unfit.

Although DMHC could exert some power over “solicitors” of plans it regulates, it has not done so. Instead, it has left it to plans to “reasonably assure itself” that solicitors are knowledgeable.

c. Others.

Importantly, the scope of fraud extends to those who are unlicensed and attempt to engage in the business of health care insurance in the state. In extraordinary circumstances, the Insurance Commissioner and DMHC Director both may seek to enjoin illegal conduct. However, generally CDI powers are greater to regulate unauthorized conduct of insurance practices.

For CDI, unlicensed producers, unlicensed insurers, and illegal products are all under the

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48 See Ins. Code §1871 et seq.
50 See e.g., Ins. Code §1631.
51 Pursuant to the provisions of Gov. Code §11500 et seq.
52 See Ins. Code §§§1668, 1738, 1742.
53 See Ins. Code §1748.5
54 See supra Section IV.A.1.
55 See 10 Cal. Code Reg. §1300.59 (“Prior to allowing any person to engage in acts of solicitation on its behalf, each plan shall reasonably assure itself that such person has sufficient knowledge of its organization, procedures, plan contracts, and the provisions of the Act and these rules to do so lawfully.”).
57 In violation of the Knox Keene Act, in Health & Safety Code §1391.
Insurance Commissioner’s general jurisdiction. Unlicensed activity is prosecuted as Cease and Desist proceedings before the Office of Administrative Hearings. Penalties for noncompliance are fines of at least $5,000 per day.

However, DMHC has no specific grant of statutory authority to challenge unlicensed entities. Importantly, a tremendous policy gap exists in this area. DMHC has authority to impose fines and penalties only on its licensees. Beyond conflict in regulation, this regulatory vacuum/oversight also makes assessment of merger of the departments a pressing policy matter.

In addition, depending on the type and nature of illegal conduct, the Insurance Commissioner may also seek injunctive relief for uncompetitive business acts pursuant to Business and Professions Code §17200. For DMHC, it is unclear whether this power is reserved to the Attorney General’s Office, and DMHC has never sought to invoke the unfair competition law.

CDI also has other, potent statutory provisions without a DMHC equivalent allowing it to challenge fraudulent practices. Beyond its consumer protection provisions and granted investigatory powers, the Insurance Code has anti-fraud laws as well as, importantly, qui tam, or whistleblower, provisions under the California Insurance Frauds Prevention Act (CIFPA). This increases the scope of CDI and incentivizes those who witness fraud to come forward for the benefit of the state and its citizens. Further, reflecting the importance of ferreting out fraud as contemplated by the Legislation, sections of the California Penal Code are specifically incorporated into the Insurance Code.

Further, the Insurance Code also allows for both civil and criminal investigations and prosecutions for the same conduct. For example, Insurance Code section 1871.7(c) states that the penalties set forth are intended to be remedial rather than punitive, and shall not preclude, nor be precluded by, a criminal prosecution for the same conduct.

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58 Pursuant to Ins. Code §12921.
59 Pursuant to Ins. Code §12921.8(a).
60 See Ins. Code §12921.8 (A) and (B).
62 However, DMHC has attempted to block its use by others. See, e.g., infra Section IV.B. (outlining DMHC efforts to block Los Angeles District Attorney from using Bus. & Prof. Code §17200 against managed care entities in rescission cases).
63 See Ins. Code §1871 et seq.
64 The CIFPA in section 1871.7(a) prohibits using runners, cappers or steerers to procure clients to obtain services or benefits under a contract of insurance. Section 1871.7(b) further provides that “any violation of this section or Section 549, 550, or 551 of the Penal Code... shall be subject to a civil penalty of not less than $5,000 nor more than $10,000 plus an assessment of not more than three times the amount of each claim for compensation (i.e. fraudulent claim presented to an insurance company).” The treble damages provision further demonstrates the harmfulness of the violations and the importance of deterring fraud.
65 As noted:

(c) The penalties set forth in subdivision (b) are intended to be remedial rather than punitive, and shall not preclude, nor be precluded by, a criminal prosecution for the same conduct. If the court finds, after considering the goals of disgorging unlawful profit, restitution, compensating the state for the costs of investigation and prosecution, and alleviating the social costs of increased insurance rates due to fraud, that such a penalty would be punitive and would preclude, or be precluded by, a criminal prosecution, the court shall reduce that penalty appropriately.

Ins. Code §1871.7(c).
The Insurance Code also provides CDI with unique flexibility in challenging fraudulent activity that does not exist with DMHC, which has no power to prosecute fraud. For example, CIFPA, together with section 650 of the Business & Professions Code prohibiting kickbacks for patient referrals, can be used to challenge a wide array of kickback schemes that are extant in health care. For example, such activities have been used by pharmaceutical companies, medical device industries, and surgery centers to persuade physicians to unnecessarily prescribe or use their most expensive products. This is a key and important power that argues for CDI leadership, since fraud is an expensive and extensive problem for California. According to the most recently available data, the cost of fraud to California is just over $8 billion each year, with no decrease predicted.

Finally, the Insurance Code and qui tam provisions allow for the potential to unearth inappropriate insurance conduct, while also generating funds, a potential that has no equivalent for DMHC. By encouraging and pursuing qui tam cases, co-counseling with private firms representing the state on a contingent fee basis, and by other means, CDI can identify more illegal behavior and increase revenues for the General Fund, the Attorney General, and itself. Specifically, the Insurance Code provides that at least 30%, but not more than 40% of any recovery will go to the whistleblower, after attorneys fees and costs are paid, while the remainder of those portions of a judgment or settlement shall be paid to the General Fund of the state, and, upon appropriation by the Legislature, shall be apportioned between the Department of Justice and the Department of Insurance for enhanced fraud investigation and prevention efforts. This extends the benefits associated with CDI powers for consumer protection to those reducing the regulatory burden and encouraging community detection of inappropriate insurer practices.

**B. Intra-governmental Collaboration.**

Regulatory efficiency can be promoted if regulatory activities are shared appropriately. This is an important potential source of costs savings and increasing resources available for expanded consumer protection by authorities with the same public policy goals.

On the one hand, CDI has a history of working with other entities to promote its consumer protection agenda. It expressly makes it an agency practice to collaborate with law enforcement entities, coordinate efforts to curb abusive practices, and make efficient use of limited governmental resources. In addition, CDI has established cooperative working

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66 In its introductory section to the Insurance Frauds Prevention Act, the California Legislature estimated in 1989 that health insurance fraud accounted for billions of dollars annually in added health care costs nationally. See Ins. Code §1871(h). Things have not gotten any better since then. The National Health Care Anti-Fraud Association conservatively estimated in 2007 that 3%, or $68 billion, of all health care spending was lost to health care fraud. See http://www.nhcaa.org/eweb/DynamicPage.aspx?webcode=anti_fraud_resource_centr.&wpscde=TheProblemOfHCFraud.

67 See id.


70 Most of the collaborative efforts entered into with allied agencies are the result of overlapping duties and Memoranda of Understandings (MOU) that incorporate language from the Insurance Code. See, e.g., Ins. Code §1874.8(c) (requiring CDI Fraud Division to work with the CHP and the district attorneys awarding grants in the
relationships with the District Attorneys of every county in California. In particular, it teams up with the District Attorneys of Sacramento and Alameda Counties to address automobile and urban automobile, life and annuity and health care, as well as worker compensation issues.  

It appears, however, that DMHC, by contrast, engages in limited if any collaboration with other state or local governmental entities. Indeed, in well publicized cases, it has actively opposed efforts by other public entities with similar goals to be involved in areas which it considers its exclusive regulatory province. For example, the Los Angeles City Attorney sought to utilize its authority under the Unfair Competition Law to protect California state residents against unlawful rescission of their health care coverage in the individual market. Instead of joining with the Los Angeles City Attorney in collaboration and cooperation, DMHC joined with the health care service plan defendants to challenge the City Attorney’s jurisdiction. Further, it participated in the litigation in concert with the health care service plans; it filed amicus briefs in the trial court in support of the plans’ demurrer, as well as on appeal in support of the plans’ writs of mandate challenging the denial of plan demurrers in the trial court, and it supported plans’ request for review of the adverse appellate decision in the California Supreme Court. In this situation, collaboration and cooperation between government entities was thwarted, and with it, loss of any potential regulatory efficiencies. But further, DMHC’s course of conduct diminished its effectiveness by diverting its limited resources from protecting consumers, and instead used them to unsuccessfully side with health care service plans and litigate against the City Attorney, who was attempting accomplish the same avowed DMHC policy goal: protect sick or injured enrollees against rescission of their health care contracts.

Hence, from a collaboration and cooperation perspective, regulatory efficiency may be best accomplished by having CDI take the lead agency role, and having DMHC merged into CDI. It also may result in greater efforts at consumer protection. Importantly, CDI would take a lead role to engage patient protections with expertise assistance from DMHC in a merged department, with the Knox Keene Act continuing to apply to all healthcare plans. This will provide CDI with the key healthcare foundation for patient protections, addressing concerns with patient protections and resources, while emphasizing appropriate fiscal approaches with extant expertise within CDI. Indeed, such a system has been contemplated for optimal regulation:

[the fact that] elected agency heads get more [from legislatures] may point to the mutually reinforcing way they can utilize a professional staff to justify requests both politically and professionally. This suggests a highly effective one-two [regulatory]

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71 See Ins. Code §1874.8 (a) and (c); and Annual Report of the Commissioner, available at http://www.insurance.ca.gov/0400-news/0200-studies-reports/0700-commissioner-report/upload/CDIAnnualReport2009.pdf; see also id. at 152-3 (budget allocations for district attorney programs); id. at 153-6 (for the results of the district attorney programs to combat fraud in auto, organized auto, disability and healthcare, and workers’ compensation lines of insurance); and id. at 159 (for the Fraud Division’s Anti-Fraud Outreach Program, which encourages ongoing communication, education, and collaboration with law enforcement, community and industry groups).

72 See Business & Professions Code §17200 et seq.


punch [using an elected agency head supported by professional staff].

In this case, CDI with an elected Insurance Commissioner with DMHC’s professional staff may be the optimal method of regulatory infrastructure to obtain the greatest consumer benefits.

C. Prosecutorial Results

Critical to any agency’s effectiveness is the ability to deter illegal conduct by prosecuting wrongdoers. Although there are various laws empowering various agencies, outcomes from such prosecutions are necessary to determine empirically relative success rates in health insurance regulatory efforts. Hence, it is important to assess this ability to determine the optimal agency to lead and one to merge.

1. CDI

Like under statutory power and intra-governmental collaboration, CDI and DMHC differ in prosecution results. On the one hand, CDI has a long history of criminal and civil prosecutions for fraudulent conduct and recovery of substantial penalties. This is especially important in the health care area because of the plethora of fraud types, such as billing for services not rendered, unbundling services to increase the charges, duplicative charges, referral fees, and kickbacks for referrals to laboratories for diagnostic testing, X-rays and other services. Chargeable fraud in California was estimated to be $719 million across all lines of insurance in 2008-2009, the most recent fiscal year for which data are available. Suspected and actual losses in 2008-2009 are estimated at $2.3 billion, about double the amount in the prior year.

CDI has investigated suspected fraudulent activity and because of its experience in coordinated efforts with other agencies, jointly have successfully brought down large scale fraudulent operations. For example, fraudulent practices by ambulatory surgical centers in Southern California generated $96 million in a fraudulent billing scheme that recruited 2,000 healthy people nationwide to receive unnecessary surgeries in exchange for money or low cost cosmetic surgery. CDI, in cooperation with the Orange County District Attorney’s Office, Department of Insurance, the Franchise Tax Board, and Medical Board of California, investigated and prosecuted this case as the largest medical fraud prosecution in the nation.

Further, of course, CDI has the statutory authority to bring criminal prosecutions, and on a showing of probable cause, to obtain search warrants for relevant documents. This is a far more rapid and efficient mechanism than investigation by civil discovery methods. Moreover, under the Insurance Code and regulations, insurance carriers are required to report fraud to CDI on an annual basis under penalty of perjury. This infrastructure is much more nimble and empowers CDI with tools that are unavailable to DMHC.

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75 See Thompson & Felts, supra at 164.
76 See California State Franchise Tax Board, Capper Pleading Guilty In the Largest Medical Insurance Fraud Case In the Nation May Be Sentenced To 20 Years, Feb. 20, 1009, available at http://www.ftb.ca.gov/aboutFTB/press/Archive/2009/09_09.shtml.
77 See, e.g., Ins. Code §1872.4, 1877.3 (specific to workers’ compensation requiring insurance carriers to report suspected fraud to the Fraud Division and local district attorneys); see also 10 Cal. Code Reg. § 2698.37 (requiring carriers to report suspected fraud); and id. §2698.40 (requiring the insurance carrier to file a Special Investigation Unit Annual Report under penalty of perjury).
A systemic approach to determining insurer fraud is extant at CDI. A special investigations audit unit is in place to look at companies’ antifraud protocols, mandated by the Insurance Code. Further, CDI audits those protocols for effectiveness. Finally, for those engaged in fraud, CDI also aggressively and successfully prosecutes fraud and assesses its outcomes, publicly releasing this information:

<table>
<thead>
<tr>
<th>CDI Fraud: All Lines Combined</th>
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</thead>
<tbody>
<tr>
<td>Suspected Fraud Claims</td>
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<tr>
<td>New Cases</td>
</tr>
<tr>
<td>Arrests</td>
</tr>
<tr>
<td>Sent to DA</td>
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<tr>
<td>Potential Loss</td>
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</table>

Source: California Department of Insurance.

<table>
<thead>
<tr>
<th>CDI -District Attorney Collaborative Program: All Lines Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investigations</td>
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<tr>
<td>Arrests</td>
</tr>
<tr>
<td>Convictions</td>
</tr>
<tr>
<td>Chargeable Fraud</td>
</tr>
<tr>
<td>Restitution</td>
</tr>
<tr>
<td>Total Funding</td>
</tr>
</tbody>
</table>

Source: California Department of Insurance.

CDI criminal prosecutions can be extremely helpful in reducing costs of health care by deterring improper and excessive billing and avoiding repeat health care visits and costs for patient-consumers. Just as kickbacks for referrals increase costs, reducing fraud decreases costs overall while also freeing resources for other consumer protection activities and minimizes redundant health care. Sentencing perpetrators to state prison and ordering restitution to victims is an important result for patient-consumers and to discipline bad actors. Such prosecution and penalties are absolutely crucial as a deterrent to fraud.

2. DMHC

By contrast, DMHC’s Enforcement Division rarely initiates administrative or civil litigation or prosecutes any matters through hearing or trial. Instead, it is charged with defending

the Department in litigation. DMHC has only a highly limited record of filing accusations or Cease & Desist Orders and of taking cases to hearing. For example, in 2005, the last year for which DMHC published figures in an Annual Report, DMHC’s Office of Enforcement only filed two Accusations and four Cease & Desist Orders for the entire year. It then suspended two of those Orders. It listed no hearings or trials whatsoever, but resolved 144 cases by letter of agreement and five by stipulated settlement agreements.

Problems with DMHC prosecutory efforts are well known. The DMHC Director, Cindy Ehnes, very publicly acknowledged the DMHC’s severe limitations as a prosecutorial entity. For example, after a survey of Blue Cross rescission practices, DMHC found the plan to be engaging in post claims underwriting. Post claims underwriting is a pernicious and illegal practice of plans accepting premiums from enrollees until they become sick or are injured and then rescinding coverage to avoid claims for expensive treatment. Rescission of coverage is only permitted by plans that had failed to properly complete medical underwriting after making the necessary finding that the enrollee had willfully misrepresented his or her health history.

The DMHC survey found that the plan’s conduct was unlawful:

The Plan does not implement the express language of section 1389.3 which requires ‘a showing of willful misrepresentation’ before it rescinds an enrollee’s coverage. The Plan does not gather sufficient information nor conduct adequate analysis to support a showing of willful misrepresentation prior to rescinding coverage.

The DMHC cited, as supporting evidence for those conclusions, that the Plan did not consistently complete medical underwriting and, in all 90 case files examined, there was no evidence the Plan, before rescinding coverage, investigated or established that the applicant’s omission/misrepresentation was willful.

DMHC announced the survey results and the assessment of a $1 million fine against Blue Cross in a press release in March, 2007. Yet it did not take action to collect the fine. In response to a question from the Associated Press regarding why DMHC did not enforce the $1 million fine it imposed against Blue Cross for its unlawful practices, Director Ehnes said that for more than a year the DMHC did not even try to enforce that fine because they knew they would be outgunned in court: “In each and every one of those rescissions, (Blue Cross has) the right to contest each, and that could tie us up in court forever.” Similarly, DMHC’s then top enforcement officer, Amy Dobberteen, said that after more than a year at the table, negotiations to get patient policies reinstated had failed and that “we are pursuing vigorous enforcement now.” Dobberteen further noted that the DMHC had warning of what it was up against when it fined Blue Cross for a single rescission in 2006. Dobberteen described the insurer as “engaging in an exhausting back-and-forth” that made it clear that addressing the larger number of

80 Id. at 41.
81 See Non-Routine Medical Survey of Blue Cross of California, issued to the public file, March 23, 2007.
82 See Appendix A.
83 See Shaya Tayefe Mohajer, State didn’t try to collect fine from Blue Cross: Health care enforcers admit they knew they’d be outgunned in court, Associated Press, July 4, 2008 (attached in Appendix B).
rescissions would mean “a very large fight.” It appears, then, that the DMHC approach clearly
does not disincentivize illegally acting plans, compared with the thousands of cases successfully
prosecuted under CDI authority.

As a consequence, the practice at DMHC has been to settle virtually all matters rather
than engage in strong prosecutions, as its Annual Reports and publically available information
demonstrate.

<table>
<thead>
<tr>
<th>DMHC Categories</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases Opened</td>
<td>423</td>
<td>458</td>
<td>344</td>
</tr>
<tr>
<td>Anti-Fraud</td>
<td>110</td>
<td>98</td>
<td>109</td>
</tr>
<tr>
<td>Cases Closed</td>
<td>308</td>
<td>376</td>
<td>362</td>
</tr>
<tr>
<td>Anti-Fraud</td>
<td>106</td>
<td>96</td>
<td>104</td>
</tr>
<tr>
<td>Hours to Close Cases</td>
<td>22,201.29</td>
<td>15,325.66</td>
<td>13,873.35</td>
</tr>
<tr>
<td>Anti-Fraud</td>
<td>262.2</td>
<td>744.85</td>
<td>477.35</td>
</tr>
<tr>
<td>Various Violations</td>
<td>13,551.44</td>
<td>6,129.25</td>
<td>10,149.25</td>
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<tr>
<td>Enforcement Actions</td>
<td>88</td>
<td>139</td>
<td>172</td>
</tr>
<tr>
<td>Accusations/Cease desist</td>
<td>11</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Letters of agreement</td>
<td>54</td>
<td>133</td>
<td>144</td>
</tr>
</tbody>
</table>

Source: California Department of Managed Health Care.

Importantly, this DMHC strategy has not resulted in significant consumer protection. For
example, as to DMHC’s rescission cases, settlements between DMHC and illegally acting plans
have resulted in essentially no recovery for consumers. DMHC reported to the Assembly
Committee on Accountability and Administrative Review that DMHC sent letters to 3,366
former enrollees informing them of their rights under the settlement agreements with health plans. DMHC informed the Committee that 177 individuals accepted new coverage, 301
individuals expressed interest in an expedited review process, which included an option for
enrollees to negotiate directly with the plan, and ten chose to arbitrate their claims directly with
the plans. DMHC further indicated that it had not collected information on the number of
consumers who received payment through the arbitration process or the amount of money
involved.

A report prepared for the Committee on the effectiveness of the DMHC settlements
found that only a small fraction of eligible Californians benefited from agreements that DMHC

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84 See Mohajer, supra.
85 See Letter to Mark Martin dated December 16, 2009, attached as Appendix C.
made with Anthem Blue Cross and other insurers to settle accusations that they systematically and illegally dropped sick policyholders to avoid paying for their care. The report, based on data from the regulators, concluded that so few eligible consumers benefitted because the terms of the settlements conflicted, were too complicated, used jargon and legalese, and made little if any effort to address cultural competency issues or health literacy concerns. The report also noted that for every single DMHC-illegally acting plan settlement negotiation, patient-consumers were excluded from any and all discussions.

Committee chair Hector De La Torre (D-South Gate) said the results were “pretty pathetic when you are talking about thousands” of policies that were rescinded. Yet DMHC claimed at the Committee’s hearing that the 5% or so recovery rate “could not be improved on” and was “the best outcome”. Others have also questioned the propriety of these settlements.

Even the DMHC, which negotiated the settlements, concluded that “[M]any consumers whose rights were violated received less than restorative justice.” However, DMHC did not acknowledge that its dense and complicated 18 page notice in English to rescinded patient-consumers could have discouraged participation, but instead claimed that the disappointing result was “no doubt” attributable to confusion caused “in part” by the multiplicity of litigation caused by the Los Angeles City Attorney.

Consequently, it appears that CDI has the more focused, experienced, and mature system of collaborative consumer protection and successful prosecutions against illegally acting entities. Indeed, DMHC has limited actual and exerted powers, and has left consumers with less than optimal outcomes. From this vantage point, CDI leadership in a merged entity would lead to stronger deterrence of unlawful practices and greater safeguards for consumers. This result is especially important, as California patient-consumers continue to suffer from inappropriate denials of coverage across DMHC regulated health care plans in the state.

### D. Medicare Advantage Market


87 Enrollees were given confusing information about whether they had to opt out of pending class cases and give up any right to private litigation in order to participate in the DMHC review process. The answer to one frequently asked question said: “You are free to pursue private litigation rather than participate in the expedited review options”; elsewhere in the same document enrollees were told their legal rights to pursue private litigation may be affected if they participate in the DMHC process “and accept compensation”. See Frequently Asked Questions, DMHC Rescission Settlements, at 3 (attached in Appendix D).

88 Assembly Accountability and Administrative Review Committee Hearing, March 10, 2010.

89 Others have also criticized the DMHC approach. Nick Velasquez, a spokesman for then Los Angeles City Attorney Rockard Delgadillo, publicly said Delgadillo’s office has “serious concerns” with the settlements, including the lack of admission of wrongdoing by the health plans. Delgadillo called the settlements a “raw deal” for Californians “courtesy of the DMHC.” His office accused the DMHC of “not aggressively pursuing those health plans engaging in illegal conduct,” Velasquez said.

90 See Brief of the State of California Department of Managed Health Care Office of Enforcement, in Support of Petition for Writ of Mandate by Anthem Blue Cross of California, Inc., Anthem Blue Cross Life and Insurance Company; and WellPoint, Inc., in the Court of Appeal, Second Appellate District, Division One, dated June 29, 2009, at 25.

Increases in the payments made to private companies that offer Medicare Advantage (MA) plans through Medicare Part C in 2006 spawned an epidemic of misconduct surrounding the sale of MA plans. Medicare beneficiaries and consumer advocates have reported numerous cases of people being enrolled in plans without their knowledge and/or through deception, lies and misleading promises. Numerous media and governmental reports about marketing misconduct, and Congressional hearings, led the Centers for Medicare Services to enter Memoranda of Understanding with the Insurance Commissioners of the 50 states, and also with DMHC in California, providing for information sharing and state oversight of deceptive practices. Nevertheless, Medicare beneficiaries in California are still frequently subject to unscrupulous behavior by agents and brokers selling these products to the elderly and disabled.

To protect these growing numbers of patients, states must act aggressively to protect the highly vulnerable elderly population. California has led the nation in senior protection, and hence it is an important priority to protect these constituents. To do this, regulatory agencies must step in to ensure that the rights of the elderly are protected against abuse by fraudulent conduct by sellers of MA plans.

But because of the expansive preemption provision in federal law, CDI is the only department that is permitted to protect these vulnerable populations from such pervasive deceptive practices. Title XVIII of the Social Security Act (the Medicare Act) was amended in 2003 to significantly expand the scope of federal preemption of state laws. Whereas previously only inconsistent state laws were preempted, the Medicare Act now has a broad preemption provision which states:

The standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to MA plans which are offered by MA organizations under this part.

The Center for Medicare and Medicaid Services confirmed, in the regulations promulgated to implement the MA program, that the amendments significantly broadened the scope of federal preemption of state law.

Moreover, the breadth of federal preemption has continued and expanded under recent federal jurisprudence. For example, on August 30, 2010, the Ninth Circuit Court of Appeals held in Uhm v. Humana that the Uhms’ fraudulent misrepresentation and violation of consumer protection act claims, asserted against both a regulated health care service plan and its corporate parent, were expressly preempted by the Medicare Act. The Uhm decision is binding as precedent on federal district courts in California.

94 42 U.S.C. §1395w-26(b)(3) (emphasis added)
95 See Medicare Program; Establishment of the Medicare Advantage Program; Final Rule, 70(18) FED. REG. 4588, 4663 (Jan. 28, 2005).
However, as noted, in MA plan cases CDI does have regulatory power that allows it to effectively police the marketplace and protect elderly and disabled consumers against deceptive marketing practices. Because CDI licenses the brokers and agents selling MA plans, any enforcement action against deceptive sales practices by brokers and agents would fall squarely within the “other than State licensing laws or State laws relating to plan solvency” exclusion from federal preemption.

On the other hand, the *Uhm* decision and its progeny impose a very substantial impediment to any DMHC efforts to police brokers/agents. Although DMHC potentially regulates agent and broker conduct, it does not license them. Therefore, any enforcement action it might pursue could fall outside the federal licensing exception and could be preempted. The DMHC has invoked its statutory remedies of suspension orders on a few occasions. But the issuance of one such order against three broker/agents resulted in the brokers filing an injunctive action against DMHC in federal court for the Central District of California on preemption grounds, which will be decided in the future.

Hence, regulating MA plans and other federal program beneficiaries would be subject to strong federal preemption language. From this perspective, merging DMHC into CDI would obviate the preemption issue. Since CDI’s licensing efforts are indisputably outside preemption, at a minimum CDI can curb and deter deceptive solicitations by brokers and agents selling Medicare Advantage products to the elderly and disabled.

E. Collaboration and Coordination Nationwide

Learning from peers is essential to promote effective and efficient policymaking. States as crucibles of regulatory experimentation can yield best practices for the benefit of the polity. For insurance, the body that provides a forum for such activities is the National Association of Insurance Commissioners (NAIC).

NAIC is a national organization of state government officials who regulate the conduct of insurance companies and agents in their respective states or territories. Its mission is to assist state insurance regulators, individually and collectively, in serving the public interest and achieving the fundamental insurance regulatory goals in a responsive, efficient and cost effective manner.

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*Magistrate), aff’d and adopted, Arcadian Health Plan, Inc. v. Korfman, Case No. 1:10-cv-322-GZS (D.Me. Jan. 4, 2011)(Singal, J., U.S. District Court)) (the Medicare program enforcement role in the Medicare MA program is expressly and exclusively with the federal government, and non-licensure state laws are preempted, adopting *Uhm*). Although as previously noted, it generally foregoes such regulation and simply directs plans to “reasonably” ensure that these “solicitors” have plan knowledge. See supra Section IV.A.1.*

98 *See Salcido v. Department of Managed Health Care, No. 10-6495 GAF. Although the Court dismissed that challenge, it did so in order to abstain from interfering with the pending administrative proceedings; the issue will be joined again after those proceedings conclude and the broker/agents are likely to again allege that federal preemption is a total bar to DMHC regulation of deceptive marketing and sales practices.*

100 *These goals include: Protect the public interest; Promote competitive markets; Facilitate the fair and equitable treatment of insurance consumers; Promote the reliability, solvency and financial solidity of insurance institutions; and Support and improve state regulation of insurance.*
Importantly, NAIC seeks to foster consistency of regulatory frameworks in the various states. However, this immediately raises a concern regarding collaboration and coordination in California. Only CDI is a member of NAIC; DMHC is not a member.  

Dual regulatory agencies in California, one with NAIC membership and one without, create inefficiencies and loss of the powerful advantages NAIC can provide. NAIC represents the primary forum where states exchange ideas and communications about regulatory issues regarding healthcare and managed care, as well as implementation of federal healthcare reform. Because California is the only jurisdiction to split healthcare and managed care, and DMHC is not a NAIC member, the overlapping dual regulatory system denies California the ability to be a significant part of the managed care discussion. Further, it relies on additional relationships and steps for any agreement regarding insurance and managed care discussions that do not exist in any other state. The current structure requires extensive and not always forthcoming cooperation between CDI and DMHC, and depends heavily on the particular relationship between the Insurance Commissioner, the Director of DMHC and the Governor.

Hence, from the perspective of gaining knowledge, best practices, and uniform regulation within California and across states, merging DMHC into CDI would appear to be optimal. It would allow the Insurance Commissioner and CDI to analyze all of the NAIC issues and directives with respect to both markets as a full participant and partner, and contribute to that discussion. Emerging best practices across health delivery plans and insurers would enhance the protections afforded California consumers. As well, because NAIC addresses more than simply health insurance, learning and best practices in other regulatory areas of insurance can also be obtained through a merged entity.

F. Healthcare Reform

Evolutions in the health care industry require modernization of the regulatory architecture to keep pace. Healthcare reform is the most significant evolution in the health care industry in generations, and accordingly necessitates changes in the regulatory framework. In this arena, the regulatory question is whether CDI or DMHC will play the most appropriate role in implementation.

It appears that CDI is likely the department best suited for healthcare reform. Under the provisions of the federal Affordable Care Act, the major decision making for the implementation of federal health care reform is to be done by the Department of Health and Human Services (HHS) Secretary, Kathleen Sebelius. The ACA expressly requires the HHS Secretary to consult with Insurance Commissioners. Indeed, many of the decisions that will be made in the next year, as well as decisions to be made prior to 2014 when state insurance exchanges will begin, will be made by the HHS Secretary in consultation with the state Insurance Commissioners and NAIC.

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101 See NAIC, Member Web Map, available at http://www.naic.org/state_web_map.htm [click on members, California]
102 California, through the Insurance Commissioner, is a Member of the Healthcare and Managed Care Committee at NAIC.
103 Kelso, supra, at 10.
104 This has already occurred in the NAIC rules governing medical loss ratios that were prepared for Secretary Sebelius under the healthcare reform law.
Additionally, under federal law, insurers and health plans must submit information about their products and proposed premiums to the HHS Secretary and the state Insurance Commissioner for review. Further, the federal statute contains numerous references to federal-state collaborative efforts, and they involve and mention only state Departments of Insurance and/or NAIC. For example:

- Secretary Sebelius is working closely with NAIC and Insurance Commissioners to develop standards regarding consumer protections that will be released sometime next year.
- As a condition of receiving a state grant for rate review, a State, through its Commissioner of Insurance, shall provide the Secretary with information about trends in premium increases in health insurance coverage in premium rating areas in the State.
- The Insurance Commissioner shall make recommendations to the State Exchange about whether particular health insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases.
- The Secretary, in consultation with the National Association of Insurance Commissioners, shall define the permissible age bands for rating purposes.
- The Secretary shall consult with NAIC and Insurance Commissioners regarding state flexibility in operation, enforcement of exchanges and related requirements.
- Not later than July 1, 2013, the Secretary shall, in consultation with NAIC, issue regulations for the creation of health care choice compacts under which 2 or more States may enter into an agreement under which—
  - (A) 1 or more qualified health plans could be offered in the individual markets in all such States but, except as provided in subparagraph (B), only be subject to the laws and regulations of the State in which the plan was written or issued.
- The Secretary shall in consultation with NAIC issue rules for the offering of nationwide qualified health plans.
- The Secretary in consultation with NAIC develops guidelines for reinsurance.
- The Secretary and NAIC must work together on the development of new standards for certain Medicare Supplemental Policies.

105 Such information includes:
- Claims payment policies and practices.
- Periodic financial disclosures.
- Data on enrollment.
- Data on disenrollment.
- Data on the number of claims that are denied.
- Data on rating practices.
- Information on cost-sharing and payments with respect to any out-of-network coverage.
- Information on enrollee and participant rights.
- Other information as determined appropriate by the Secretary.

Hence, from the point of view of implementing healthcare reform, it is apparent that both the law and its regulatory provisions and forthcoming discussions all revolve around NAIC and state Insurance Commissioners. As such, it appears that CDI would be the appropriate lead department in any merged entity.

G. Solvency Models and Consumer Protection

As a substantive matter, with dueling regulatory bodies with conflicting standards such as CDI and DMHC, a merged entity would generally be left with only one set of solvency standards and rules to apply. In health care, it is absolutely imperative that solvency protections and accountability be strong because medical care is not simply a consumer good: it is a line directly to life and health.

CDI and DMHC take different tacks at solvency requirements for the entities they regulate. CDI utilizes the complex risk-based capital models developed by NAIC. Risk capital refers to the capital held by a risk-bearing organization to help assure that the organization will be able to keep its promises to its customers/members, even under very adverse circumstances. Using these NAIC standards, CDI calculates company-specific surplus requirements that reflect the risks to which an insurance company is exposed, taking into account the amount and quality of the company’s assets, the volatility of its future financial commitments, and other company-specific risks. The requirements for health insurance organizations involve a combination of asset risk, underwriting risk, credit risk and business risk. In general, minimum risk-based capital requirements for health insurance companies amount to 10% to 15% of premium income. CDI also requires insurance companies writing life and health insurance business in California to participate in the California Life and Health Insurance Guarantee Association.106 If a life and health insurance company becomes insolvent, the Association administers covered policyholder claims, and has the responsibility to pay and discharge covered claims, thus providing additional financial protections against insolvency.

DMHC, in contrast, requires plans to maintain a minimum amount of $1 million in “tangible net equity” (TNE), calculated by a formula reflective of the volume of the health care service plan’s business, but only crudely reflective of its risk exposures. TNE is defined as the excess of total assets over total liabilities, reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; long term prepayments of deferred charges, and non-returnable deposits.107 Yet researchers have noted that the risk based capital method is more finely tuned, and imposes greater capital requirements upon insurers.108 Further, a California Healthcare Foundation report on DMHC and CDI noted that “[v]irtually all key [health stakeholder] informants viewed CDI as stricter in the application of financial and claims payment standards and a more rigorous enforcer of financial solvency and reserve requirements.”109 Indeed, DMHC Director Cindy Ehnes herself concurs, noting that: “The solvency requirements for licensure under the DMHC’s regulation, while challenging for some applicants, actually represent a lower barrier than the risk-based capital standards for licensure as an insurer under the CDI.”110

106 See Ins. Code §§1067.01, 1067.04(l), 1067.02(b)(1).
107 See 28 Cal. Code Reg. §1300.76(e).
108 Kelso, supra at 48.
109 See Roth & Kelch, supra at 13.
Hence, the CDI risk-based capital model, therefore, is more protective against insolvency. Compared with DMHC efforts, CDI approaches would likely lessen the risk of plan insolvency, and consequent disruption as well as economic and other harm to enrollees and providers. Indeed, insolvency requires enrollees to find new plans, which may necessitate changing physicians, hospitals, and other providers. The new caregivers may be less conveniently located and will be unfamiliar with the enrollees and their health conditions, will be required to reinvent the wheel by additional history taking and testing, and may not take into account key patient social factors that influence care. As well, the challenge of trust building between vulnerable patients and new providers and plans creates significant challenges. Further, the enrollees may be required to undergo step therapy, trying different drugs on the new plan’s formulary and experiencing failure before receiving prescriptions for the drugs they have been taking with good results. Plan insolvency may also cause economic harm to providers because of difficulty in collecting payment for services rendered to members of an insolvent plan. All of this directly or indirectly impacts patient safety and create additional costs for remedial care.

Consequently, from a solvency and consumer protection perspective, CDI standards appear to be more robust than DMHC. Hence, to ensure the more stringent solvency rules are maintained, CDI should be the lead agency in any merged entity.

H. Oversight Action

To ensure appropriate oversight, it is imperative that premiums for healthcare are actuarially assessed by experienced regulators and challenged when inappropriate. With increasing costs and increasing premium increase requests, a key protection against profiteering is a technically oriented analysis by the relevant state agency with power to challenge.

It appears that CDI is the appropriate agency for this oversight. At the outset, it should be noted that DMHC has no actuarial expertise or experience.\textsuperscript{111} Hence, it is not well equipped to review proposed rate increases.

On the other hand, CDI has actuaries and the actuarial expertise to regulate insurance rates. For example, it has done so for 22 years for property and casualty insurance in accordance with the requirements of Proposition 103. Further, CDI also reviews proposed health insurance rate increases and challenges their calculation and legitimacy. For example, Anthem Blue Cross filed a proposed rate increase in November 2009 seeking an average rate increase of 25%. CDI did an actuarial review and found the filing to be flaw-ridden, stopped Anthem from implementing the increase for six months, and negotiated a reduction in the increase to 15%. Many other examples of CDI assessed proposed rate changes in health insurance ranging from major medical and hospital and surgical insurance have also been performed by CDI.\textsuperscript{112} They demonstrate that CDI has the power and exercises it to create a track record of challenging and refusing requested rate changes and instead negotiating much smaller appropriate rate increases, and includes many instances in which the companies requested withdrawal of the proposed rate

\textsuperscript{111} See also supra section IV.A.4(ii) (no comparable power of DMHC cf. CDI to review rate increases).
\textsuperscript{112} Requested rate increases and their results are set forth in the tables attached in Appendix E.
increase after CDI’s review.\textsuperscript{113}

CDI’s extensive oversight actions and expertise have recently extended to protecting consumers against inadequate benefits and excessive premiums in health care insurance through emergency regulation. The Insurance Commissioner on January 25, 2011 received approval from the Office of Administrative Law (OAL) for his request of an emergency regulation to give him the authority to enforce the 80\% Medical Loss Ratio (MLR) in the individual market established under healthcare reform that went into effect on January 1, 2011. The MLR is defined as the percentage of premium revenues an insurer pays for medical services, as opposed to insurer profits, marketing, and overhead. That regulation gives the Commissioner the legal authority to enforce the new federal 80\% medical loss ratio for the individual health insurance market in California, even if Congress prevents the federal Department of Health and Human Services from enforcing it.

Hence, from the point of view of oversight capabilities and action, CDI has the accounting tools, skills, and experience to assess rates and accounting, and has used them in protecting consumers by challenging inappropriate rate requests. Because DMHC has no such actuarial ability, CDI would be the logical lead agency in any merged entity.

V. Conclusion

On the basis of public accountability, regulatory efficiency and cost savings, revenue generating potential, investigative and prosecutorial powers and effectiveness and regulatory oversight experience, it appears that a merged entity is an appropriate policy consideration to more openly, effectively, and efficiently regulate the health care markets. Further, because of the advantages of CDI over DMHC, CDI should be the lead agency in any merged entity.

\textsuperscript{113} Such as over the period January 2007 through May 2010.
APPENDICES
FOR IMMEDIATE RELEASE
March 22, 2007

CONTACT: Lynne Randolph
(916) 445-7442

Department of Managed Health Care fines Blue Cross of California for illegally rescinding health insurance policies
Survey report shows two violations of state law

(Sacramento) – The Department of Managed Health Care (DMHC) has fined Blue Cross of California $1 million for routinely rescinding health insurance policies in violation of state law. The fine is based on a non-routine survey report that used a random sample of individual health insurance policies that were rescinded by Blue Cross from January 1, 2004, to January 1, 2006. The survey was conducted after complaints from Blue Cross members that their policies were rescinded after they had submitted a health insurance claim or after they received medical treatment.

“Our report reinforces suspicions that Blue Cross’ practices irreparably harm the consumer by issuing policies without doing the proper medical underwriting up front or proving that policyholders intentionally withheld information during the application process,” said Cindy Ehnes, Director of the DMHC. “Not only is the consumer then responsible for large medical bills, these practices hinder an individual’s ability to get and keep health coverage. Therefore, health plan practices are suspect when coverage is snatched away when claims for services are filed.”

The report of survey findings, conducted by the DMHC’s Division of Plan Surveys within its HMO Help Center, summarizes the review of ninety randomly-chosen cases involving policy rescissions, and cites two deficiencies for failure to comply with state law. The first deficiency found that in 39 of 90 cases, there was no evidence that Blue Cross conducted a thorough and complete pre-enrollment investigation of the applicant’s medical

(more)
history, or conformed to its own underwriting policies before issuing health coverage. The second deficiency found that, in all 90 cases, Blue Cross did not prove that an applicant willfully misrepresented his or her medical history before coverage was rescinded.

Since late 2005, the DMHC has been investigating California health plans that offer individual health policies, including Blue Cross, for engaging in the illegal practice of post-claims underwriting. Health plans are required to assess an applicant’s medical risk and resolve all reasonable questions about a health condition before issuing health coverage. In addition, prior to rescinding an individual policy, state law requires the plan to show that a policyholder willfully or intentionally misrepresented material information on an application.

In September 2006, the DMHC fined Blue Cross $200,000 for rescinding the health insurance policy of one of its members in violation of state law. The fine was the first to be imposed in the multi-health plan investigation. The DMHC has also fined Kaiser Foundation Health Plan $325,000 for two illegal rescissions. Kaiser agreed to settle both cases and is currently cooperating with the DMHC in an effort to improve its practices. Although Blue Cross is challenging its penalty, the plan has agreed to implement changes to improve its processes.

A complete copy of the survey report can be found on the DMHC Web site at www.dmhca.ca.gov, under the Announcements section on the home page.

The California Department of Managed Health Care is the only stand-alone HMO watchdog agency in the nation, touching the lives of more than 21 million enrollees. The DMHC has assisted more than 633,000 Californians through its 24-hour Help Center to resolve health plan problems, educates consumers on health care rights and responsibilities, and works closely with HMO plans to ensure a solvent and stable managed health care system.

###
State didn't try to collect fine from Blue Cross

Health care enforcers admit they knew they'd be outgunned in court

July 04, 2008|By Shaya Tayefe Mohajer, Associated Press

Los Angeles — California regulators admitted Thursday that for more than a year they didn't even try to enforce a million-dollar fine against health insurer Anthem Blue Cross because they knew they would be outgunned in court.

In early 2007, the Department of Managed Health Care pledged to fine the state's largest insurer for "routinely rescinding health insurance policies in violation of state law."

But it never did.

The department's director, Cindy Ehnes, said Thursday that, when it comes to rescissions, the agency has succeeded in forcing smaller insurers to reinstate illegally canceled policies and pay fines, but Blue Cross is too powerful to take on.

"In each and every one of those rescissions, (Blue Cross has) the right to contest each, and that could tie us up in court forever," Ehnes said of about 1,770 Blue Cross rescissions since Jan. 1, 2004.

"They have the largest number of rescissions, so as a practical matter for the department it does present some practical challenges that are different from a Health Net (of California) or a PacifiCare," referring to providers who, along with Kaiser Permanente, have made settlements with the state to reinstate health care coverage.

That means that although Anthem Blue Cross has the highest number of alleged illegal rescissions, it may face the least regulatory consequence simply because of its sheer size and its skill in legal intimidation.

Anthem Blue Cross, a unit of WellPoint Inc., acknowledged Thursday that it had seen the March 22, 2007, announcement of the $1 million fine, but noted that "Anthem Blue Cross has not been fined by the DMHC."

The statement went on to say that the insurer is "in the midst of settlement discussions."
However, the agency's top enforcement officer, Amy Dobberteen, said Thursday that after more than a year at the table, negotiations to get patient policies reinstated had failed and that "we are pursuing vigorous enforcement now."

The agency had warning of what it was up against when it fined Anthem Blue Cross $200,000 for a single rescission in 2006. Dobberteen said the insurer engaged in an exhausting back-and-forth that made it clear that addressing the larger number of rescissions would mean "a very large fight."

The DMHC fine announcement came on the heels of Gov. Arnold Schwarzenegger's announced comprehensive health care proposal in January 2007, according to gubernatorial adviser Daniel Zingale. Schwarzenegger has spoken out sharply against the practice of rescission, which drops enrollees when they try to make claims on health insurance policies.

"Blue Cross, what they've done is terrible by refusing to go along with these negotiations," Zingale said. "When a company stands outside the fold, then they end up getting the fine and the law."

The Republican governor's proposal failed, the fine remained just a long-ago announcement and some critics say that's no coincidence.

"This is a fraud on the people of California," said Jerry Flanagan, health advocate for Consumer Watchdog, a consumer advocacy group in Santa Monica. "The governor's top regulator talks tough about collecting big fines and then never bothers to ask the company to pay up. In the mind of the governor, it's the best of both worlds: He gets the splashy headlines he likes but he keeps his insurance company pals close."

Anthem Blue Cross and its parent have given the Schwarzenegger campaign more than $256,600 in campaign contributions, according to Consumer Watchdog.
December 16, 2009

VIA HAND DELIVERY

Mark Martin
California State Assembly Consultant
Assembly Committee on Accountability and Administrative Review
Legislative Office Building
1020 N Street, Room 357
Sacramento, CA 95814

RE: REQUEST FOR DOCUMENTS AND INFORMATION
ProLaw No.: 2009-2365

Dear Mr. Martin:

The Department of Managed Health Care ("DMHC") is in receipt of your November 16, 2009 request for information and documents related to the 2008 rescission settlement agreements entered into by the DMHC and the health plans involved.¹ For your convenience, below I have restated each of your requests followed by the corresponding responsive information.

Request 1: "A copy of the letter explaining the settlement agreement that was sent out to rescinded consumers."

Response: Enclosed with this letter are copies of the template letters that were sent to former enrollees of the plans subject to the settlement agreements. The template letters vary somewhat for each plan.

Please also note that for some plans slightly different letters were sent to "former enrollees" and "specified former enrollees," as those terms are defined within the various settlement agreements. With respect to those plans for which two different letters were sent, I have enclosed the templates of the letter sent to former enrollees and the letter sent to specified former enrollees.

Request 2: "The number of consumers who were sent letters."

Response: Three thousand three hundred sixty-six (3,366) former enrollees were sent letters informing them of their rights under the settlement agreements.

¹ The plans that entered into settlement agreements with the DMHC regarding rescission practices were: Blue Cross, Blue Shield, Kaiser, PacificCare, and Health Net.
Request 3: "The number of consumers who received the letters."
Response: There were 2,715 confirmed receipts of the letters sent to enrollees.

Request 4: "The number of consumers who accepted new coverage due to the letters."
Response: One hundred seventy-seven (177) individuals have accepted new coverage as provided by the settlement agreements.

Request 5: "The number of consumers who accepted the arbitration process that was included in the settlement."
Response: Three hundred one (301) individuals have expressed interest in the Expedited Review Process provide by the settlement agreements, which includes an option of negotiating directly with the plan. Ten of the 301 individuals have chosen to arbitrate their claims directly with the plans.

Request 6: "The number of consumers who received payment due to the arbitration process, and the amount of money awarded through that process."
Response: The DMHC has not collected this information.

Request 7: "The number of consumers who pursued private litigation, if the department knows that information."
Response: The DMHC has not collected this information.

Request 8: "The amount of money collected in fines from the major insurers regarding rescissions based on actions taken by the department since 2006."
Response: The DMHC has collected the full amount that was levied in fines against the plans, for a total of $13,650,000 collected to date.

Request 9: Copies of the Corrective Action Plans for the insurers who agreed to create a CAP.
Response: Copies of the operative CAPs are enclosed with this letter.

Should you have any questions or concerns regarding the information set forth above or the documents enclosed, please do not hesitate to contact me at (916) 324-2522.

Sincerely,

Sarah Ream
Staff Counsel III
Office of Legal Services

SR: sr
Enclosures
FAQs
DMHC Rescission Settlements

The California Department of Managed Health Care has reached agreements with Blue Shield, Anthem Blue Cross, Kaiser, Health Net, and PacifiCare requiring them to offer health care coverage to former members whose policies they rescinded or cancelled over the past four years, regardless of the former member's health condition. California is the first state in the nation to bring consumers this groundbreaking opportunity to regain health care coverage and reimbursement for medical expenses incurred during the time that a consumer was uninsured.

Information about how former members can take advantage of this program are now being mailed to the approximately 3,400 eligible Californians. These "Notice Packets" contain information about two parts of the settlement, Part A and Part B.

Part A explains how former members can regain health coverage. It contains an Offer of Coverage from the health plan that explains how the health plan's rescinded or cancelled members can now purchase an individual policy that is similar to the rescinded or cancelled policy. The health plan can not review or consider the buyer's health records to deny coverage. The buyer has 90 days to accept this Offer of Coverage.

Part B describes how former members can seek reimbursement for any medical expenses they had to pay while they were uninsured that should have been paid by the health plan. It provides an Expedited Review Process for resolving financial disputes with the health plan, such as payment for the medical expenses incurred after the policy was rescinded or cancelled. Rescinded or cancelled members have 90 days to complete the Interest Form and mail it to the health plan to obtain detailed information.

I was rescinded, but didn't receive a Notice Packet. What do I do now?
Call the DMHC's HMO Help Center at 1-888-466-2219 to see if you qualify.

The Notice says that I am eligible for "guaranteed issue of health coverage." What does that mean?
Guaranteed issue of coverage means that a health plan has agreed to offer former members health coverage regardless of current or past health status. Former members eligible for these offers of coverage will automatically be accepted for coverage. This concept is one that Governor Schwarzenegger has included in his health care reform proposals to enable all Californians to get health coverage, regardless of health status.

Will my family also be covered?
The DMHC Settlement Agreements are for rescinded members only. If your rescinded coverage was a family plan and the entire family was rescinded, your family may be eligible for coverage, depending on the terms of the plan. You will need to discuss directly with your health plan.

Appendix D
My Notice says I am a Specified Former Enrollee. What does this mean?
This means that you are entitled to reimbursement for Out-Of-Pocket Medical Expenses when you provide documentation of your expenses to your health plan, without regard to whether the rescission was appropriate.

Once I re-purchase an individual health care policy from my health plan, will I be able to keep it, even if I develop a serious illness?
As long as you meet coverage requirements, such as paying your premiums on time, and do not violate the law in your usage of the coverage, you can remain a health plan member until you become eligible for Medicare.

How much time do I have to accept this Offer of Coverage?
You have 90 days from the date that the Notice Packet was delivered to your address to submit your completed application to the health plan in the pre-paid envelope included in the Notice Packet. Some plans also require the first month’s premium to be included with your application. Check your Notice Packet carefully to see what your health plan requires.

When will my new health coverage start?
Coverage will begin on the first day of the month following the health plan’s receipt of your completed application and in some cases, also the first month’s premium. Check your Notice Packet carefully to be sure that you have included everything your health plan requires.

If I decline the Offer of Coverage in Part A, can I still participate in Part B to resolve my claims?
Yes. If you want to decline the Offer of Coverage, you can still participate in Part B to resolve any potential medical claims/expenses you incurred as a result of your policy rescission/cancellation.

How do I resolve my claims through the Part B Expedited Review Process?
You must complete the Interest Form and mail it to your health plan within 90 days, using the pre-paid envelope that you received in your Notice Packet. The health plan will then send additional information explaining various options for resolving your claims, which include resolving them directly with the health plan, or having an independent arbitrator determine whether you are entitled to damages. You will also receive information telling you how to submit your bills for your Out-of-Pocket Medical Expenses or claims. If you do not receive your materials within 15 days from the date you mailed back your Interest Form, you should call the Department of Managed Health Care at 1-888-466-2219, or your health plan. You will be given additional time to review this information after you receive it, and to choose whether to participate.

If I don’t participate in the Part B Expedited Review Process, how can I have my claims resolved?
You are free to pursue private litigation rather than participate in the expedited review options. You may want to consult an attorney regarding your legal rights.

**If I participate in the Part B Expedited Review Process, can I still sue privately?**
Your legal rights may be affected if you participate in the Part B process and accept compensation for your medical expenses or other claims. You may, however, accept the Part A Offer of Coverage without affecting your legal rights. The decision to participate in the DMHC Rescission Settlements is yours alone. Please consult your attorney regarding your legal rights.

**I am a member of a class action suit against my health plan. Should I participate in the DMHC Rescission Settlement?**
You should discuss this with your attorney to determine whether the DMHC Rescission Settlement or the class action suits would yield the best results for you. The DMHC Rescission Settlement will enable you to purchase health coverage immediately, regardless of the state of your health, and this can be accepted even if you are a class member. It will also offer you the chance to obtain reimbursement for medical claims/expenses you incurred as a result of the rescission or cancellation. The DMHC does not have any information at this time about the details of the class action suits.

**May I use an attorney to help prepare and submit documentation of my medical expenses or participate in the Expedited Review Process?**
Yes, you may use an attorney if you wish, but you are not required to do so.

**What if I still have questions?**
- You can call your health plan:
  - Health Net – Renew Program Assistance Line, at 1-818-676-8609
  - Kaiser – Fresh Start Program Assistance Line, at 1-866-525-0603
  - PacifiCare – 1-920-661-3066
  - Anthem Blue Cross – Reinstatement Program Assistance Line, at 1-800-333-0912.
  - Blue Shield – Re-Enrollment Program Assistance Line, at 1-888-575-3439.
- You can call the DMHC’s Help Center at 1-888-466-2219.
<table>
<thead>
<tr>
<th>COMPANY NAME</th>
<th>PAB File/ State Tracking Number</th>
<th>Type of Coverage</th>
<th>Date Closed Out by PAB</th>
<th>Rate Change(s) Requested</th>
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Appendix E
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<tr>
<td>67</td>
<td>GENWORTH LIFE AND ANNUITY INS CO</td>
<td>PF-2009-00371</td>
<td>Major Medical</td>
<td>5/21/2009</td>
<td>+39.0%</td>
<td>+23.3%</td>
</tr>
<tr>
<td>68</td>
<td>AXA EQUITABLE LIFE INS CO</td>
<td>PF-2009-01244</td>
<td>Major Medical</td>
<td>7/8/2009</td>
<td>+8.0%</td>
<td></td>
</tr>
<tr>
<td>69</td>
<td>AETNA LIFE INS CO</td>
<td>PF-2009-00114</td>
<td>Medical Expense</td>
<td>7/16/2009</td>
<td>+17.3%</td>
<td></td>
</tr>
<tr>
<td>70</td>
<td>PRUDENTIAL INS CO OF AMERICA (THE)</td>
<td>PF-2009-01361</td>
<td>Major Medical - SERFF</td>
<td>8/7/2009</td>
<td>+15.0%</td>
<td>+10.0%</td>
</tr>
<tr>
<td>71</td>
<td>PRUDENTIAL INS CO OF AMERICA (THE)</td>
<td>PF-2009-01252</td>
<td>Major Medical - SERFF</td>
<td>8/21/2009</td>
<td>+15.0%</td>
<td>+10.0%</td>
</tr>
<tr>
<td>72</td>
<td>GLOBE LIFE AND ACCIDENT INS CO</td>
<td>PF-2009-01563</td>
<td>Hospital &amp; Surgical Expense - SERFF</td>
<td>8/27/2009</td>
<td>+10.0%</td>
<td>+10.0%</td>
</tr>
<tr>
<td>73</td>
<td>CONTINENTAL GENERAL INS CO</td>
<td>PF-2009-01566</td>
<td>Major Medical - SERFF</td>
<td>10/30/2009</td>
<td>+22.0%</td>
<td>Following the rate increase review, the company requested withdrawal of the rate increase</td>
</tr>
<tr>
<td>74</td>
<td>TRUSTMARK INS CO</td>
<td>PF-2009-01948</td>
<td>Major Medical - SERFF</td>
<td>10/30/2009</td>
<td>+9.0%</td>
<td>Following the rate increase review, the company requested withdrawal of the rate increase</td>
</tr>
<tr>
<td>75</td>
<td>PRUDENTIAL INS CO OF AMERICA (THE)</td>
<td>PF-2009-01784</td>
<td>Major Medical - SERFF</td>
<td>11/2/2009</td>
<td>+10.0%</td>
<td></td>
</tr>
<tr>
<td>76</td>
<td>NORTHWESTERN NATIONAL INS CO OF MILWAUKEE, WISCONSIN</td>
<td>PF-2009-01797</td>
<td>Hospital &amp; Surgical Expense</td>
<td>11/18/2009</td>
<td>+12.0%</td>
<td></td>
</tr>
<tr>
<td>77</td>
<td>TRUSTMARK INS CO</td>
<td>PF-2009-01481</td>
<td>Major Medical - SERFF</td>
<td>11/19/2009</td>
<td>+15.0%</td>
<td>+10.0%</td>
</tr>
<tr>
<td>78</td>
<td>CENTRAL UNITED LIFE INS CO</td>
<td>PF-2009-01946</td>
<td>Hospital &amp; Surgical Expense - SERFF</td>
<td>12/3/2009</td>
<td>+10.0%</td>
<td>Following the rate increase review, the company requested withdrawal of the rate increase</td>
</tr>
<tr>
<td>79</td>
<td>CONNECTICUT GENERAL LIFE INS CO</td>
<td>PF-2009-02139</td>
<td>Major Medical - SERFF</td>
<td>1/21/2010</td>
<td>An Average of +14.0%</td>
<td>An Average of +12.0%</td>
</tr>
<tr>
<td>#</td>
<td>Company Name</td>
<td>Plan Code</td>
<td>Plan Type</td>
<td>Date</td>
<td>Rate Change</td>
<td>Reason</td>
</tr>
<tr>
<td>----</td>
<td>--------------------------------------</td>
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<td>---------------------------</td>
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<td>-------------</td>
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</tr>
<tr>
<td>80</td>
<td>GLOBE LIFE AND ACCIDENT INS CO</td>
<td>PF-2009-01712</td>
<td>Hospital &amp; Surgical Expense - SERFF</td>
<td>1/26/2010</td>
<td>+10.0%</td>
<td></td>
</tr>
<tr>
<td>81</td>
<td>ANTHEM BLUE CROSS LIFE AND HEALTH INS CO</td>
<td>PF-2009-02089</td>
<td>Major Medical</td>
<td>4/29/2010</td>
<td>+29.1%</td>
<td>Following the rate increase review, the company requested withdrawal of the rate increase</td>
</tr>
<tr>
<td>82</td>
<td>ANTHEM BLUE CROSS LIFE AND HEALTH INS CO</td>
<td>PF-2009-02090</td>
<td>Major Medical</td>
<td>4/29/2010</td>
<td>+16.3%</td>
<td>Following the rate increase review, the company requested withdrawal of the rate increase</td>
</tr>
<tr>
<td>83</td>
<td>ANTHEM BLUE CROSS LIFE AND HEALTH INS CO</td>
<td>PF-2009-02091</td>
<td>Major Medical</td>
<td>4/29/2010</td>
<td>+16.6%</td>
<td>Following the rate increase review, the company requested withdrawal of the rate increase</td>
</tr>
<tr>
<td>84</td>
<td>ANTHEM BLUE CROSS LIFE AND HEALTH INS CO</td>
<td>PF-2009-02092</td>
<td>Major Medical</td>
<td>4/29/2010</td>
<td>Plans that EXclude maternity coverage: +12.3%; Plans that INclude maternity coverage: +12.3%</td>
<td>Following the rate increase review, the company requested withdrawal of the rate increase</td>
</tr>
<tr>
<td>85</td>
<td>ANTHEM BLUE CROSS LIFE AND HEALTH INS CO</td>
<td>PF-2009-02094</td>
<td>Major Medical</td>
<td>4/29/2010</td>
<td>+22.8%</td>
<td>Following the rate increase review, the company requested withdrawal of the rate increase</td>
</tr>
<tr>
<td>86</td>
<td>ANTHEM BLUE CROSS LIFE AND HEALTH INS CO</td>
<td>PF-2009-02096</td>
<td>Major Medical</td>
<td>4/29/2010</td>
<td>+29.5%</td>
<td>Following the rate increase review, the company requested withdrawal of the rate increase</td>
</tr>
<tr>
<td>87</td>
<td>ANTHEM BLUE CROSS LIFE AND HEALTH INS CO</td>
<td>PF-2009-02097</td>
<td>Major Medical</td>
<td>4/29/2010</td>
<td>+32.0%</td>
<td>Following the rate increase review, the company requested withdrawal of the rate increase</td>
</tr>
<tr>
<td>88</td>
<td>HEALTH NET LIFE INS CO</td>
<td>PF-2010-00310</td>
<td>PPO Rates</td>
<td>4/30/2010</td>
<td>+20.0%</td>
<td></td>
</tr>
<tr>
<td>89</td>
<td>METROPOLITAN LIFE INS CO</td>
<td>PF-2009-01671</td>
<td>Individual Medical Indemnity</td>
<td>5/11/2010</td>
<td>+30.0%</td>
<td>+15.0%</td>
</tr>
<tr>
<td>90</td>
<td>GUARDIAN LIFE INS CO OF AMERICA (THE)</td>
<td>PF-2010-00498</td>
<td>Major Medical - SERFF</td>
<td>5/11/2010</td>
<td>+15.0%</td>
<td>+10.0%</td>
</tr>
</tbody>
</table>