RESCISSION BACKGROUND

Rescission is the practice used by health insurers to eliminate insurance coverage from an individual or an individual's family. Rescission is typically based on a review of the individual's initial application for coverage that the insurer determines to have included omissions or discrepancies in the individual's health history. Many critics have argued that insurance companies have rescinded coverage after an individual gets sick and faces costly medical care.

Rescission is not allowed in group health care coverage, which is typically provided by employers, and only affects the individual health insurance market —small businesses, the self-employed or unemployed who seek individual coverage. About 2.6 million of the 28 million Californians who have health coverage have individual plans, or about 9 percent.

Both Insurance Code Section 10384 and Health and Safety Code Section 1389.3 prohibit health insurers from rescinding or canceling insurance based on "post-claims underwriting," which is when insurers conduct a thorough review of the individual's initial application to search for minor errors after the individual has begun to incur medical costs.

While health plans maintain that a post-claims review process is necessary to detect fraud, investigations by the news media, state and federal agencies and allegations in private litigation indicate insurers have purposely used confusing applications and minor discrepancies to abuse the rescission process and avoid costs. For example, documents released in a lawsuit filed by the Los Angeles City Attorney against insurer Health Net revealed that company's compensation and bonus structure for some employees was tied to meeting or exceeding annual rescission quotas.

The individual health insurance market in California is regulated by both the California Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI). DMHC regulates health care service plans, including health maintenance organizations and some Preferred Provider Organization plans; CDI regulates other lines of insurance, including disability insurers who offer health insurance. Many health insurance companies are regulated by both departments because they offer multiple types of insurance programs.

Both agencies have conducted rescission investigations during the past five years and alleged that insurers have engaged in wrongful rescissions. According to settlement agreements reached between the departments and insurance companies in 2008 and 2009, more than 6,000 Californians were subject to rescissions by the five largest insurance companies between 2004 and 2008.

In addition to the state agencies' actions on rescission, numerous private lawsuits have been filed on behalf of rescinded consumers. Most notably, the Los Angeles City Attorney's Office, working with private attorneys, has sued Health Net, Blue Shield and Blue Cross. The lawsuits claim that the rescissions violate the state's Unfair Competition Law and False Advertising Law.

In a June 29, 2009 Amicus Curiae brief filed by DMHC in a California Court of Appeal case regarding whether the Los Angeles City Attorney has the right to sue Blue Cross, DMHC has sided with Blue Cross, arguing the city has no jurisdiction and the settlement agreements it reached with health plans, including Blue Cross, should be the final action on the rescission issue.

RESCISSION SETTLEMENT AGREEMENTS

Both the California Department of Insurance (CDI) and the California Department of Managed Health Care (DMHC) conducted investigations of rescissions among various health insurers between 2005 and 2008.

CDI investigated each insurer under its authority, although for larger insurers, such as Anthem Blue Cross, the Department used a sampling method instead of looking at each individual rescission case. According to a written response to a question posed by the Committee, the Department "did not systemically determine how many rescissions were valid."

DMHC conducted rescission reviews of the five largest health plans under its authority. The surveys led to penalties against Anthem Blue Cross and Kaiser Foundation Health Plan in 2006 and 2007. However, the Associated Press in 2008 reported that DMHC had not pursued the collection of a $1 million fine it had announced a year earlier. DMHC also fined Health Net of California $1 million in 2007 for failing to disclose to the Department that it tied some employee compensation and bonuses to meeting rescission quotas.

The investigations eventually led to settlement agreements between the two state agencies and five major insurers. DMHC reached agreement with Health Net, Blue Cross, Blue Shield of California, PacifiCare of California, and Kaiser in 2008. CDI reached agreements with Health Net and Blue Shield in 2008 and with Blue Cross in early 2009.

While some critics have contended the Departments should have pursued a regulatory hearing process that would have included public hearings —and public disclosure— as to the insurers' rescission activities, the Departments argue seeking settlement agreements saved the state money in legal costs and allowed for stronger remedies to help rescinded consumers than they could have gained in a regulatory proceeding.

Some of the key elements of the agreements, which covered 6,006 rescinded enrollees, include:

- ***An end to formal proceedings.*** The agreements essentially ended investigations of rescission by the Departments. All of the agreements stipulate that the insurers did not acknowledge any wrong-doing, and all agreements allow rescissions to continue on a going-forward basis.
- ***Fines.*** Insurers paid fines in each agreement except the agreement between CDI and Blue Shield. Of the agreements that included fines, the amount ranged from $50,000 paid by PacifiCare to $10 million, paid by Blue Cross. Both Departments indicated to the Committee that all fines have been received by the state.
- ***New coverage for rescinded enrollees.*** In each of the agreements, insurers agreed to offer new coverage to the rescinded enrollees. The coverage was offered regardless of the health status of the individual or their family, and was set at market rates —there was no discount offered.
- ***A process for rescinded enrollees to recoup some medical costs.*** Under the DMHC agreements, a small group of rescinded enrollees —40 out of 3,366— who had been identified in DMHC investigations as having been wrongfully rescinded were allowed to

submit receipts and proof of medical costs for reimbursement, with the health plans required to pay all bills.

Other rescinded enrollees were given the opportunity to seek reimbursement, but the health plans were allowed to refute claims, and an arbitration process was set up to resolve disputes.

The CDI agreements allowed rescinded enrollees to submit proof of medical costs to the insurers, with an arbitration process set up to resolve disputes. In all cases, consumers who accept the reimbursement process outlined in the agreements are prohibited from participating in any other legal action against the insurers.

- ***Corrective Action Plans.*** All of the agreements required insurers to develop Corrective Action Plans to change some processes and policies regarding rescission, including:
  - Creating applications that were easier to understand;
  - Developing more thorough processes to evaluate consumers' applications before they were accepted;
  - Earlier notification to consumers that a rescission investigation had begun and they were in danger of losing coverage;
  - A more thorough process for consumers to appeal rescissions;
  - And an internal audit process to monitor rescissions.
- ***Independent Third Party Review.*** CDI's agreements required insurers to develop an Independent Third Party Review process that would review proposed rescission decisions before they occur. DMHC's agreements did not require Independent Third Party Review, although two health plans —Health Net and Blue Cross— have created Independent Third Party Review processes as part of their Corrective Action Plans.

INVOLVED PARTIES	SETTLEMENT DATE	NUMBER OF RESCISSIONS	DAMAGES	FINE	NEW COVERAGE	REIMBURSEMENT PROCESS	GOING FORWARD
DMHC/Health Net	05/15/2008	85	Possible	$300,000	Yes	Deal with company/arbitration	CAP
DMHC/PacifiCare	06/11/2008	64	Possible	$50,000	Yes	Deal with company/arbitration	CAP
DMHC/Blue Cross	08/11/2008	1773	Possible	$10 Million	Yes	Deal with company/arbitration	CAP
DMHC/Blue Shield	07/18/2008	450	Possible	$3 Million	Yes	Deal with company/arbitration	CAP
DMHC/Kaiser	05/12/2008	1092	Possible	$300,000	Yes	Deal with company/arbitration	CAP
CDI/Health Net	08/15/2008	926	Possible	$3.6 Million	Yes	Deal with company/arbitration	CAP, 3rd Party Review
CDI/Blue Shield	12/29/2008	678	No	0	Yes	Deal with company/arbitration	CAP, 3rd Party Review
CDI/Blue Cross	02/09/2009	2092	No	$1 Million	Yes	Deal with company/arbitration	CAP, 3rd Party Review
LA/Health Net	02/11/2009	977	$3 Million	$2 Million	Yes	Reimbursement	Rescission moratorium

The agreements reached by the two Departments were similar in most aspects. Both Departments required insurers to offer new coverage to rescinded enrollees, both provided a reimbursement process, and both required new policies going forward to ensure that the rescission process was more structured. Only CDI, however, required the insurers it regulates to create an Independent Third Party Review process.

The Departments argue that the settlements have dramatically reduced the practice of rescission. In testimony to Congress in 2008, Dale Bonner, Secretary of the California Business, Transportation and Housing Agency, said that rescissions dropped by 81 percent in the first year after DMHC

began enforcement actions. The Departments also note that the settlements allowed rescinded enrollees a chance to receive new coverage and recoup some medical expenses.

There are critics of the settlements, however. In a September 3, 2008 letter, Deputy Attorney General Carol S. Jimenez wrote that lawyers in the California Attorney General's Office "have consistently expressed significant concerns about fairness to rescinded enrollees in the agreed-upon restitution process," and that the Office was concerned that the letters sent to rescinded enrollees lacked clarity.

In a letter to DMHC, the organization Consumer Watchdog criticized the Department's agreement with PacifiCare, arguing the arbitration process favored health plans with large legal teams, did not allow consumers the opportunity to help select an arbitrator, and allowed the health plan too much leeway to design its own Corrective Action Plan. The California Medical Association criticized DMHC's agreement with Blue Cross in a court filing, noting that former enrollees are not allowed to recover the premiums they paid to Blue Cross before they were rescinded.

A comparison can be made between the settlements reached between insurers and the two state agencies and one agreement reached between the Los Angeles City Attorney, working with private attorneys, and Health Net. In that agreement, reached in February 2009, Health Net agreed to:

- Pay a $2 million fine, compared to a $300,000 fine paid to DMHC and a $3.6 million fine paid to CDI;
- Distribute $3.15 million in damages, divided evenly between the rescinded enrollees, compared to no damages paid to enrollees in the DMHC and CDI settlements;
- Distribute another $3.15 million to rescinded enrollees based on medical expenses submitted by the enrollees, compared to the DMHC and CDI settlements, which, for most rescinded enrollees, set up a process in which they must negotiate with the companies or enter an arbitration process to recover expenses.
- Offer new coverage to former enrollees, regardless of health history or status, at market rates, which is similar to the offers in the DMHC and CDI settlements;
- Not rescind any enrollee for at least one year and until it develops an Independent Third Party Review process to evaluate future rescissions, compared to the DMHC settlements which forbid rescissions for enrollees who were enrolled in plans as of 2008 but do not require the development of an Independent Third Party Review Process, and compared to the CDI settlements, which forbid rescissions for enrollees who were enrolled in plans as of 2008 and required the creation of an Independent Third Party Review process.

Attachments:

- *September 3, 2008 letter from California Attorney General's Office*
- *July 3, 2008 letter from Consumer Watchdog*
- *Portion of the July 16, 2009 Amicus Curiae Brief from the California Medical Association in Court of Appeal, 2nd Appellate District, Anthem Blue Cross v. Superior Court of the State of California*
- *Dale E. Bonner, Secretary, California Business, Transportation and Housing Agency. July 17, 2008. Testimony before the United States House of Representatives Committee on Oversight and Government Reform.*

RESCISSION SETTLEMENT IMPLEMENTATION

Implementing the settlement agreements involved several components: letters were mailed to consumers notifying them of the settlement, consumers had the option of accepting new health insurance, consumers had the right to attempt to recoup medical costs associated with their rescission, and the companies were required to produce Corrective Action Plans to change processes related to rescission.

According to data provided by Department of Managed Health Care (DMHC) and California Department of Insurance (CDI) to the Assembly Committee on Accountability and Administrative Review, a small fraction of consumers benefited from the settlement agreements.

Five percent of rescinded enrollees eligible for new insurance coverage under DMHC's agreements accepted new coverage. Less than four percent of rescinded enrollees eligible for new coverage under CDI's agreements accepted new coverage.

In addition, 92 rescinded enrollees out of 3,366 —less than three percent— participated in arbitration processes set up by DMHC to recoup medical expenses incurred after rescission. About $870,000 in medical and other expenses were recouped. A process set up by CDI to help Blue Cross consumers recover expenses due to rescissions netted 78 consumers for a total of $798,270, about six percent of the $14 million in expenses CDI claimed could be collected in a press release.

Finally, Corrective Action Plans required by all health insurers to reform rescission practices are not fully in place, even though more than one year has passed since all of the settlement agreements were reached.

The following is an analysis by Committee staff of the settlement implementation, based on information provided to the Committee by both DMHC and CDI, and interviews with CDI and DMHC staff.

- ***Letters.*** Each settlement required companies to conduct "reasonable efforts" to track down former enrollees to make them aware of the settlement and their rights under the settlement. DMHC sent letters to the former enrollees using its letterhead. Unlike the DMHC agreements, under the CDI agreements the insurers sent letters to the former enrollees using the insurers' letterhead. While DMHC sent out letters to consumers an average of 2 ½ months after settlements were announced, CDI's process took much longer: letters to Health Net consumers were not sent out until one year after the settlement was announced, while letters to Blue Shield consumers did not go out to consumers until 10 months after the settlement was announced. About 81 percent of rescinded enrollees covered by the DMHC agreements actually received letters; about 85 percent of rescinded enrollees covered by CDI agreements actually received letters.
- ***New coverage.*** According to DMHC, 177 of 3,366 rescinded enrollees accepted the offer of new health insurance based on the settlements. CDI reported that 104 of 2,622 rescinded enrollees accepted the offer of new health insurance based on CDI's settlements. (CDI's settlement also affected 18 people who were rescinded by Health

Net; their participation rates are not yet known by the Department.) The new coverage offered was to be offered at market rates, where premiums for individual coverage rose 23 percent between 2002 and 2006.

- ***Financial recovery process.*** Each agreement allowed rescinded enrollees an opportunity to recoup some costs incurred due to the rescission, but participation rates in these processes have been low. According to DMHC data, 301 of the 3,366 rescinded enrollees covered under their agreements requested more information about the recovery process from DMHC, but only 10 people actually pursued the process. The Committee asked DMHC to provide the total amount of money gained by those who sought reimbursement, but the Department indicated it did not know the amount.

  CDI does not yet have information about the recovery process for consumers rescinded by Health Net and Blue Shield, but does have data on the process for Blue Cross consumers. According to CDI, 78 people recouped $798,270 from Blue Cross. In a February 11, 2009 press release, Insurance Commissioner Steve Poizner stated that rescinded consumers could receive a total of $14 million in reimbursements from Blue Cross.

  In comparison, rescinded Health Net consumers covered by a settlement reached between Health Net and the Los Angeles City Attorney have received nearly $5.5 million in payments from Health Net in damages and reimbursements, according to information provided by the City Attorney's Office. Of more than $6 million that was available to consumers, $188,000 in checks were delivered to consumers but not cashed, and $390,000 in checks were undelivered because consumers could not be located.

- ***Corrective Action Plans.*** Under the agreements reached by CDI, insurers were required to submit a Corrective Action Plan and then implement the plan within four months of Department approval. Both Blue Cross and Blue Shield face fines if CDI determines they have not implemented the plan, but the Health Net settlement does not stipulate a possible fine. CDI told the Committee that negotiations over the plans were ongoing and final plans were not available. DMHC's agreements required each health plan to submit a Corrective Action Plan in June, July or August 2008, depending on the agreement. The health plans have four months to implement the plans after final Department approval, and each face fines if they are found to have failed to implement the plan. DMHC provided the Committee with draft Corrective Action Plans for each health plan, but it does not appear that final versions are complete.

  A preliminary analysis of the documents DMHC provided to the Committee indicate that the health plans are proposing differing practices on some issues that may make it difficult for state regulators, as it sets up different standards at different health plans. For example, two companies, Health Net and Blue Cross, propose to create Independent Third Party Review processes to examine each proposed rescission; while the other three companies do not. PacifiCare states that it will follow up with consumers who provide vague information on applications "when appropriate," but there is no description of what that means. Blue Shield proposes to notify consumers that a rescission investigation has been conducted and they may lose their coverage in

15 days; other plans have proposed notifying consumers earlier in their rescission process.

AGENCY	SENT LETTERS	RECEIVED LETTERS	ACCEPTED NEW COVERAGE	PARTICIPATED IN RECOVERY	AMOUNT RECOVERED
DMHC	3366	2715	177	92	About $870,000
CDI	2640	2242	104 (Only BC & BS known)	BC - 78; (others unknown)	$798,270.12 (Only BC)

In addition to the settlement agreements, both DMHC and CDI announced on October 23, 2007 that they would issue joint regulations to clarify several rescission-related issues, including requiring less ambiguous applications, requiring state review of rescissions, and prohibiting the cancellation of policies covering entire families if only one individual misrepresented his or her health history. CDI officials told the Committee that new regulations will be in place by May. DMHC, however, has abandoned the rule-making process.