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Congress of the United States
House of Representatives
Committee on Oversight and Government Reform

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Mr. Chairman and Committee Members:

My name is Dale Bonner and I am the Secretary of the California Business, Transportation and Housing Agency, which oversees the California Department of Managed Health Care (Department), responsible for regulating the 107 managed care plans that operate in California. The Department is the only stand-alone state agency in the nation with the responsibility for sole oversight of HMOs, touching the lives of nearly 21 million Californians.

Thank you for inviting me to attend this hearing to talk about the actions taken by the Department to combat the improper rescissions of health care coverage. With me today is Amy Dobberteen, Chief of the Department's Enforcement Division. She is here to help answer any questions concerning enforcement actions.

In early 2006, the Department began the largest investigation of wrongful rescissions ever undertaken in the nation. These investigations of the five largest plans in California offering individual coverage -- Anthem Blue Cross, Blue Shield of California, Kaiser, PacifiCare and Health Net -- were conducted through the Department's Division of Plan Surveys, and have resulted in coordinated enforcement actions to shine a light on and bring an end to the improper use of rescission.

The Department proactively began these investigations after receiving numerous consumer complaints and learning of private class action litigation against Kaiser Permanente and Anthem Blue Cross.

These efforts have been extremely successful, and have changed industry practice in terms of underwriting processes and better consumer disclosure. As a result of the Department's aggressive oversight and enforcement actions, the number of rescissions in California dropped 81 percent the first year.

I will begin by briefly explaining what rescission is and why it is so devastating to those who experience it.

In California, there are two types of insurance – group, and individual.

Group health care coverage is provided through employers or large groups, and health plans base these premium rates on a large diverse group of people, knowing that the many who are relatively healthy will offset the cost of providing coverage to those who are not. Pre-existing conditions or state of health are not factors in who receives coverage. However, in California and elsewhere, laws protect access to coverage and rates paid by smaller groups of up to 50 employees.

Individual health coverage is for those who do not have access to group insurance, often those who are self-employed or who are employed by small businesses. Individual coverage is subject to medical underwriting – a process that allows an insurer to select which applicants it will cover, based on information supplied by the applicant on an extensive medical history questionnaire. Applicants can be denied coverage altogether or be subject to higher premiums if they have in the past been treated for ailments as minor as acne, allergies, or ringworm. Only individual insurance is subject to rescission, because it is issued based on medical underwriting.

Rescission is a harsh practice and differs from cancellation of coverage in one important way. While cancellation of coverage leaves the individual without coverage going forward, the claims incurred to date are paid. Rescission, on the other hand, is a legal remedy that treats the coverage as never having been approved in the first place. It completely wipes out a person's history of ever having coverage at all and holds the enrollee liable for all medical expenses that were paid by the plan since the issuance of the policy. It renders a person both uninsured, often in the middle of care, as well as uninsurable in the future. In addition, an entire family's coverage may be wiped out, based upon the presumed guilt of the primary enrollee.

Proper uses for rescission do exist. Health plans have the right under current California law to use rescission as a method of stopping fraud on the part of enrollees who have misrepresented their health histories in order to obtain coverage. Health plans understandably assert that they must be able to police their risk pools from fraud in order to keep premiums affordable for the entire group. Because of the potential for consumer misrepresentation on the application, it can sometimes be difficult for plans to determine whether a misrepresentation or omission was the result of fraud or inadvertence.

The problem with rescission arises when a plan engages in post-claims underwriting, which is prohibited under California's Knox-Keene Act, and defined as reevaluating the risk or underwriting *after* a claim is filed, which can lead to rescission of coverage. Current law state*s that "the insurer must either complete medical underwriting up front OR show that the enrollee willfully omitted or misrepresented information on the application."*

It became apparent during the Department's investigations that all the plans followed little or no consistent processes when investigating the medical history of the applicant or in determining whether to rescind coverage. In numerous instances, plans did not investigate obvious questions about an enrollee's health history on an application, nor did they take reasonable steps to complete underwriting before issuing coverage. But they rescinded the coverage anyway, with limited recourse for the enrollee.

One of the things that is most troubling is that these actions are usually taken because enrollees are using health services. As a result, when they are rescinded, it can seriously disrupt a course of treatment and negatively affect the person's health, as well as exposing their families to large unexpected financial risks that could result in bankruptcy. In addition, it severely erodes faith in the individual market among consumers and their providers who already treated them in good faith because the health plan had authorized the treatment.

The Department's investigations and actions, including a total of $3.175 million in fines to date, as well as required process changes, have played a large role in the reduction in rescissions. Working in conjunction with the California Attorney General to ensure that enrollees are properly notified of how to exercise their rights as well as collaborating with the California Department of Insurance, the Department was able to bring about changes in applications that make it easier for applicants to understand, and to require fair processes for investigation of rescissions that include the right to appeal. Because of the Department's investigation, most of the plans in California voluntarily began changing their processes, including improving their internal policies and procedures to provide a fair process for consumers.

In addition, in April of this year, the Department announced that it would review each and every rescission case from the five plans dating back to 2004. This announcement prompted negotiations leading to settlements with three health plans so far: Kaiser Permanente, Health Net, and PacifiCare.

The settlements specify that:

- All previously rescinded enrollees of the three plans will be offered guaranteed issue coverage.
- Individuals will get coverage quickly, and it will be permanent and not subject to potential legal challenges.
- Pre-rescission out-of-pocket medical expenses will be paid by the plan.

- Consumers will get a convenient, no-cost opportunity to recover any additional damages without having to go through lengthy, costly, or uncertain legal battles.

Unfortunately, the Department has not yet reached a similar settlement with Anthem Blue Cross or Blue Shield of California. As a result, the Department will conduct an immediate review of all of their rescission cases to determine whether they applied the correct legal standard to justify the rescission. If violations have occurred, the Department will order the coverage restored and apply the appropriate fines. Given the 2,177 cases involved, these fines could very well be the largest the Department has ever assessed.

With these actions, the Department has achieved what it set out to do:

- Changed the national landscape to stop the unfair and illegal practice of rescission by holding plans accountable.
- Made sure that health plans are fair and consumers understand what is being asked of them on health history applications.
- Jumped in to restore coverage as broadly as possible for patients unfairly rescinded in the middle of care.
- Avoided lengthy court battles for individuals seeking monetary reimbursement from the plans.
- Restored confidence in the individual market.

Governor Schwarzenegger has already signed legislation making it illegal for health plans to re-collect or offset future payments for services that they already authorized on behalf of rescinded patient. The Governor will also be working with our legislature this year to outlaw bonuses or economic incentives to health plan employees for rescinding patient coverage, and to provide stronger consumer protections, such as standardizing the application process, improving consumer notification requirements, and allowing independent review panels to decide whether a rescission of coverage is appropriate.

In the longer term, the Governor wants to render these practices unnecessary by instituting guaranteed issuance of individual coverage coupled with an individual mandate.

The California Department of Managed Health Care will continue to vigorously enforce the law for the benefit of consumers and will continue to send a strong message that illegal rescissions will not be tolerated.

Appendix 1
Summary of DMHC Enforcement Actions and Case Summaries

The Department's Office of Enforcement and Division of Plan Surveys has proactively investigated rescission of individual health care coverage since early 2006 after receiving numerous consumer complaints and learning of private class action litigation against Kaiser Foundation Health Plan and Blue Cross of California. The Department has completed or pending surveys of all plans offering individual underwritten health care coverage[1] and its Office of Enforcement has taken the following actions:

In September 2006, the Department filed an Accusation against Blue Cross and assessed a $200,000 penalty for wrongful rescission, in violation of section 1389.3, because Blue Cross failed to complete pre-enrollment medical underwriting and rescinded an enrollee based on a condition she disclosed before Blue Cross approved coverage for her and some members of her family. Blue Cross is contesting the Accusation, but the matter is not yet scheduled for hearing.

On October 6, 2006, the Department ordered Kaiser to reinstate a member who had been covered under a Kaiser group-plan for 20 years. During that time Kaiser treated her for arm and neck pain and filled her prescriptions through its pharmacies. Thus, it was on notice of her arm and neck condition at the time she applied for individual coverage. Nevertheless, Kaiser rescinded the member's coverage because she did not disclose her neck and arm pain even though the enrollee reasonably believed Kaiser was aware of the condition. The member also had a congenital kidney disease and contacted the Department at a time when she was uninsured and believed she would need emergency care for the kidney condition. Because Kaiser was on notice of the member's arm and neck pain at the time it approved her application, the Department ordered Kaiser to reinstate her coverage to allow her to obtain medically necessary services for her kidney condition.

On December 13, 2006, the Department and Kaiser entered into a Letter of Agreement to settle a wrongful rescission case where Kaiser rescinded a member for failing to disclose signs and symptoms of epilepsy when the member had never been formally diagnosed. Kaiser contested liability in the case but agreed to pay a $100,000 penalty to settle the matter.

On March 1, 2007, Kaiser and the Department entered into a second Letter of Agreement wherein Kaiser agreed to pay $225,000 for a wrongful rescission where an internal data input error caused the wrongful rescission of the member's coverage. The member disclosed several pre-existing conditions and a Kaiser employee omitted a disclosure of kidney stones. It was this initial defect in Kaiser's underwriting process that led to wrongful rescission of the enrollee's coverage. As a result, Kaiser failed to properly

[1] The Department's Division of Plan Surveys conducted Non-Routine Medical Surveys of Blue Cross of California, Blue Shield of California, Kaiser Foundation Health Plan, Health Net of California, and PacifiCare.

complete medical underwriting and also failed to prove that the member willfully misrepresented his health history before rescinding coverage in violation of section 1389.3 of the Knox-Keene Act.

In May of 2006, the Department initiated its first Non-Routine Medical Survey of Blue Cross of California. The survey team reviewed 90 files of rescinded enrollees and found various deficiencies including Blue Cross's failure to properly investigate whether the enrollees it rescinded willfully misrepresented their health history to obtain health care coverage in violation of Health and Safety Code, section 1389. The Department is now undertaking a review of all rescinded cases during the survey period.

In November 2007, the Department entered into a Consent Agreement with Health Net of California after it learned that Health Net had deliberately misrepresented the existence of an employee bonus and incentive plan that was directly tied to the number of rescinded health care contracts and the resulting cost savings to Health Net. The Department took immediate enforcement action and entered into a Consent Agreement wherein Health Net agreed to pay a $1 million penalty.

Appendix 2

Summary of DMHC Fine Against Health Net

The Department assessed and collected a $1 million penalty from Health Net of California, for failing to appropriately disclose the existence of Health Net's bonus and incentive plan for employees in its underwriting Department. Representatives of the Department's survey team twice inquired of Health Net representatives, in connection with a non-routine survey assessing plan practices regarding rescission, whether any compensation, bonuses, or incentives for employees in its underwriting Department were tied to either the number of rescissions completed or cost savings to Health Net arising from rescissions. Health Net representatives affirmatively represented to the survey team that no such bonus or incentive programs existed, and claimed that bonuses and compensation incentives were awarded based solely on (1) Health Net's overall financial performance, and (2) job performance.

Only after an Order was obtained in a private arbitration case requiring Health Net to produce public employee performance evaluations, compensation and bonus structure, and press coverage was imminent, did Health Net reveal that its Senior Risk Analyst's compensation and bonus structure were tied to meeting or exceeding annual quotas and goals for rescinding health care coverage and the overall cost savings to Health Net resulting from those rescissions, and that she received a portion of her annual bonus for pursuing rescission of health care contracts.

Appendix 3
Summary of DMHC Settlement Agreements

Health Net Reinstatement Agreement Summary

Summary of Sanctioned Conduct

- The Plan did not consistently follow its medical underwriting policies, procedures and guidelines before issuing health insurance contracts.

- Because the Plan did not implement nor consistently follow policies, procedures and underwriting guidelines to ensure that it completed medical underwriting before issuing health insurance contracts, the Plan was required to show or demonstrate that the applicant willfully misrepresented health history on the applicant form before making a determination to rescind the applicant's health coverage. The Plan did not consistently show (document) that it applied the willful misrepresentation standard to its rescission determinations.

Benefits to Former Enrollees

- Plan will not rescind any coverage issued prior to May 15, 2008.

- Within 45 days, Plan will begin contacting former enrollees to extend coverage without any medical underwriting conditions. The offer will be open for 90 days.

- Enrollee may pursue any additional legal remedies.

- For those not contacted directly by the plan, the offer of coverage will be extended, if requested by the individual, until December 31, 2008.

- Any medical charges incurred by the former enrollee during the time they had prior Health Net coverage will either be forgiven or refunded.

- Three Expedited Dispute Resolution Options are offered. Arbitration decisions are final:
    - Negotiate claims directly with Health Net – submit a written claim for damages supported by documentation. Plan will settle or dispute within 60 days. If disputed, claimant may pursue other available options.
    - Claims less than $25,000 may be resolved through expedited proceeding conducted by a JAMS arbitrator on the basis of a written record.
    - Claims more than $25,000 or which include claims for damages other than paid out-of-pocket medical expenses may be resolved through binding arbitration administered by JAMS.

Benefits to Initial (Specified) Enrollees

- The initial enrollees will be offered immediate coverage without any medical underwriting conditions.

- Any medical charges incurred by the initial enrollee during the time they had prior coverage to the present will be offered by the Plan in the form of a financial settlement.

- If the financial settlement is disputed, the amount will be decided by an independent third-party review on an expedited basis, but the Plan cannot defend its rescission determination.

- If the enrollee accepts the independent arbitration award, it will be final and no additional remedies can be sought.

Requirements and Penalties for the Health Plan

- Coverage starting now no matter the health status of enrollee.

- Plan will pay all medical claims decided through independent arbitration.

- Plan will pay all claims submitted by newly-covered enrollees.

- Plan will pay an administrative fine of $300,000 upfront and $3 million within one year if it does not complete corrective actions.

Corrective Action

- Corrective actions will be completed by the Plan within 120 calendar days of the DMHC's written approval of the proposal. Corrective actions should include:
    - Clear and understandable applications, including health history questionnaires.
    - Reasonable look-back time periods on health histories.
    - Review of health history prior to issue coverage.
    - Verifying accuracy of health history statements, taking into consideration language barriers and statements from brokers and agents.
    - Notification to applicant if a Plan investigation is taking place.
    - Any rescission determination is considered by staff independent of original underwriting process.
    - An impartial grievance and appeal process.

- As noted above, if the Plan does not substantially and implement the corrective actions within one year, the Plan will pay an additional administrative fine of $3 million.

- On or before December 31, 2008, the DMHC will conduct a follow-up survey to determine compliance with corrective actions.

PacifiCare Health Coverage Reinstatement Agreement Summary
Summary of Sanctioned Conduct

- The Plan did not consistently follow its medical underwriting policies, procedures and guidelines before issuing health insurance contracts.

- Because the Plan did not implement nor consistently follow policies, procedures and underwriting guidelines to ensure that it completed medical underwriting before issuing health insurance contracts, the Plan was required to show or demonstrate that the applicant willfully misrepresented health history on the applicant form before making a determination to rescind the applicant's health coverage. The Plan did not consistently show (document) that it applied the willful misrepresentation standard to its rescission determinations.

Benefits to Former Enrollees

- Offer arbitration concurrently for any cancellation or rescission contracts issued before June 11, 2008.

- Within 45 days, Plan will begin contacting former enrollees to extend coverage without any medical underwriting conditions. The offer will be open for 90 days.

- Enrollee may pursue any additional legal remedies.

- For those not contacted directly by the plan, the offer of coverage will be extended, if requested by the individual, until December 31, 2008.

- Any medical charges incurred by the former enrollee during the time they had prior PacifiCare coverage is not at issue due to Plan's cancellation policy.

- Three Expedited Dispute Resolution Options are offered. Arbitration decisions are final:
    1. Negotiate claims directly with PacifiCare – submit a written claim for damages supported by documentation. Plan will settle or dispute within 60 days. If disputed, claimant may pursue Options 2 or 3.
    2. Claims less than $25,000 may be resolved through expedited proceeding conducted by a JAMS arbitrator on the basis of a written record.
    3. Claims more than $25,000 or which include claims for damages other than paid out-of-pocket medical expenses may be resolved through binding arbitration administered by JAMS.

Benefits to Initial (Specified) Enrollees

- The initial enrollees will be offered immediate coverage without any medical underwriting conditions.

- Any medical charges incurred by the initial enrollee during the gap period to the present will be offered by the Plan in the form of a financial settlement.

- If the financial settlement is disputed, the amount will be decided by an independent third-party review on an expedited basis, but the Plan cannot defend its rescission determination.

- If the enrollee accepts the independent arbitration award, it will be final and no additional remedies can be sought.

Requirements and Penalties for the Health Plan

- Coverage starting now no matter the health status of enrollee.

- Plan will pay all medical claims decided through independent arbitration.

- Plan will pay an administrative fine of $50,000 upfront and up to $500,000 if it does not complete corrective actions as confirmed through a follow-up medical survey scheduled within the next 18 months.

Corrective Action

- Corrective actions will be completed by the Plan within 120 calendar days of the DMHC's written approval of the proposal. Corrective actions should include:
  - Clear and understandable applications, including health history questionnaires.
  - Reasonable look-back time periods on health histories.
  - Review of health history prior to issue coverage.
  - Verifying accuracy of health history statements, taking into consideration language barriers and statements from brokers and agents.
  - Notification to applicant if a Plan investigation is taking place.
  - Any rescission determination is considered by staff independent of original underwriting process.
  - An impartial grievance and appeal process.

- If the Plan does not substantially implement the corrective actions, confirmed within the next 18 months, the Plan will pay an additional administrative fine of up to $500,000.

Kaiser Reinstatement Agreement Summary

Summary of Sanctioned Conduct

- The Plan did not consistently follow its medical underwriting policies, procedures and guidelines before issuing health insurance contracts.

- Because the Plan did not implement nor consistently follow policies, procedures and underwriting guidelines to ensure that it completed medical underwriting before issuing health insurance contracts, the Plan was required to show or demonstrate that the applicant willfully misrepresented health history on the applicant form before making a determination to rescind the applicant's health coverage. The Plan did not consistently show (document) that it applied the willful misrepresentation standard to its rescission determinations.

Benefits to Former Enrollees

- Plan will not rescind any coverage issued prior to May 15, 2008.

- Within 45 days, Plan will begin contacting former enrollees to extend coverage without any medical underwriting conditions. The offer will be open for 90 days.

- Enrollee may pursue any additional legal remedies.

- For those not contacted directly by the plan, the offer of coverage will be extended, if requested by the individual, until December 31, 2008.

- Any medical charges incurred by the former enrollee during the time they had prior Kaiser coverage will either be forgiven or refunded.

- Three Expedited Dispute Resolution Options are offered. Arbitration decisions are final:
    - Negotiate claims directly with Kaiser – submit a written claim for damages supported by documentation. Plan will settle or dispute within 60 days. If disputed, claimant may pursue other available options.
    - Claims less than $15,000 may be resolved through expedited proceeding conducted by a JAMS arbitrator on the basis of a written record.
    - Claims more than $15,000 or which include claims for damages other than paid out-of-pocket medical expenses may be resolved through binding arbitration administered by JAMS.

Benefits to Initial (Specified) Enrollees

- The initial enrollees will be offered immediate coverage without any medical underwriting conditions.

- Any medical charges incurred by the initial enrollee during the time they had prior coverage to the present will be offered by the Plan in the form of a financial settlement.

- If the financial settlement is disputed, the amount will be decided by an independent third-party review on an expedited basis, but the Plan cannot defend its rescission determination.

- If the enrollee accepts the independent arbitration award, it will be final and no additional remedies can be sought.

Requirements and Penalties for the Health Plan

- Coverage starting now no matter the health status of enrollee.

- Plan will pay all medical claims decided through independent arbitration.

- Plan will pay all claims submitted by newly-covered enrollees.

- Plan will pay an administrative fine of $300,000 upfront and $3 million within one year if it does not complete corrective actions.

Corrective Action

- Corrective actions will be completed by the Plan within 120 calendar days of the DMHC's written approval of the proposal. Corrective actions should include:
    - Clear and understandable applications, including health history questionnaires.
    - Reasonable look-back time periods on health histories
    - Review of health history prior to issue coverage.
    - Verifying accuracy of health history statements, taking into consideration language barriers and statements from brokers and agents.
    - Notification to applicant if a Plan investigation is taking place.
    - Any rescission determination is considered by staff independent of original underwriting process.
    - An impartial grievance and appeal process.

- As noted above, if the Plan does not substantially and implement the corrective actions within one year, the Plan will pay an additional administrative fine of $3 million.

- On or before December 31, 2008, the DMHC will conduct a follow-up survey to determine compliance with corrective actions.