

Regulators aim to curb healthcare rescissions

Rules would have firms check applicants' fitness before issuing policies.

By Lisa Girion, Los Angeles Times Staff Writer
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State regulators moved Tuesday to limit insurers' ability to cancel medical coverage after patients get sick, proposing that companies be required to check up on an applicant's health before issuing a policy in the first place.

The Department of Managed Health Care, which governs health plans known as HMOs, and the Department of Insurance, which supervises insurance companies, said they would propose rules that reinforced existing laws forbidding rescissions except when they could show a policyholder was at fault. It marked the first time the two agencies had acted in concert on any regulations.

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"We felt that it was extremely important that consumers be protected regardless of the insurance product they had and we wanted to send a very strong message nationally that we regard this practice as one that must be done away with," healthcare agency Director Cindy Ehnes said.

Gov. Arnold Schwarzenegger recently signed into law a bill introduced by Assemblyman Hector De La Torre (D-South Gate) that will require insurers to pay hospitals and physicians for authorized care even if insurers later revoke coverage. The law takes effect in January.

Both the proposed regulations and the bill were drafted to address problems associated with the loss of coverage that were highlighted in a series of articles in The Times. A state investigation into rescissions led to fines against Blue Cross of California and Kaiser Permanente.

Insurance Commissioner Steve Poizner said the two agencies wanted consumers and the industry "to know that we will stand shoulder to shoulder to address" unjust rescissions.

The agencies said they would propose parallel regulations drawn from laws that forbid insurers from withdrawing coverage unless a policyholder knowingly lied or omitted medical history information to obtain a policy.

Insurers, which have said that they rescind a small fraction of policies and that the practice is a responsible hedge against fraud, called the proposed regulations overly broad and costly. Patient advocates said they didn't go far enough.

Insurers maintain that California law states a company doesn't have to prove that an applicant for

a policy intended to mislead the company for it to cancel coverage.

The proposed regulations say that a company can't cancel coverage unless a policyholder makes a "willful misrepresentation" on an application.

"The law makes it clear that rescission generally does not require a showing of 'intent to deceive' or 'willful misrepresentation,'" said Shannon Troughton, a spokeswoman for Blue Cross parent WellPoint Inc.

Blue Shield spokesman David Seldin said new rules could become a burden for consumers.

"We are concerned that a broad requirement to prove willfulness will make it harder and more expensive for individuals to obtain coverage," he said.

The Foundation for Taxpayer and Consumer Rights had petitioned the agencies for rules against rescissions and said the first draft was disappointing.

Spokesman Jerry Flanagan said that to protect consumers, regulators must step in and require that insurers prove policyholder misconduct before allowing a company to carry out a cancellation.

"They've restated the law here fairly well, but that's not the point," Flanagan said. "They are supposed to establish a process for making sure that the cancellations are fair and patients are protected."

Healthcare agency spokeswoman Lynne Randolph said that people already had the right to ask the agency to step in and stop an unjust rescission. The problem now is that a rescission letter is often the first notice. The proposed rules would require health plans to inform policyholders that their coverage was under investigation and then make a decision within 30 days.

The proposed rules, which must undergo a formal public comment period pending adoption, may open a new front in the rescission battle.

Insurers and health maintenance organizations already are fighting canceled policyholders in courtrooms across the state to defend their practices. The health plans maintain that the law allows them to assume that the information in an application is correct and to issue coverage without reviewing medical records.

The plans also argue that the law allows them to investigate medical claims and to revoke coverage if they discover pertinent information that wasn't disclosed in an application.

State appellate courts in Los Angeles and Santa Ana have heard arguments in the two most advanced cases, both involving Blue Shield. The industry, consumer groups and regulators are awaiting rulings.

The proposed rules may encourage more litigation because they don't create a process for arbitrating rescissions before insurers carry them out, said Bryan Liang, executive director of the Institute of Health Law Studies at California Western School of Law in San Diego.

"This is not doing anything different than restating what the law says," he said. "We haven't moved forward."

Regulators are seeking to eliminate the causes of rescissions by requiring companies to do more work before issuing coverage. Through a process known as medical underwriting, companies would be required to assess an applicant's fitness by looking at information in such resources as medical records, the insurers' own claims files and commercially available databases.

"It's a major step in the right direction," said Bill Shernoff, a Claremont lawyer who is representing hundreds of canceled policyholders in suits against insurers. "A lot of the stuff in these regulations are things we've been saying all along. But it's nice to see it in writing."