LEGISLATIVE LAW

Insurance Industry Continues Unscrupulous Rescission Practice

by Hector De La Torre
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Hector De La Torre (D-South Gate) represents California's 50th Assembly District, which covers a portion of southern Los Angeles County, including the cities of Bell Gardens, Commerce, Downey and South Gate. In the Assembly, Mr. De La Torre chairs the Accountability and Administrative Review Committee and serves on the Budget Committee, the Health Committee and the Housing and Community Development Committee. Assemblyman De La Torre also is a candidate for California Insurance Commissioner.

The insurance industry has made billions of dollars by unfairly canceling health policies, with little to no oversight prior to cancellation. As the national health care debate rages, Californians understand that people who get sick deserve to get coverage for care that they paid for. Anything less is unacceptable.

Purchasing health care coverage in the individual market can be expensive and often requires families to tighten their budgets. Families face tough choices—often dictated by financial impacts and not by what is best for their health.

Added to this stress is the potential battle with their insurer over coverage. Insurance companies are engaging in a practice of rescission—canceling a patient's health care coverage retroactively. Even if a family has being paying the premiums on time for five years, 10 years, or longer, there are no protections for the consumer.

Worse yet, who is the judge and jury for rescission? Insurance companies act as the sole decision makers when moving to rescind coverage. State regulators have no authority to approve or deny a rescission. Typically, insurance companies rescind a policy by arguing that a consumer lied or did not provide adequate information when applying for health care coverage. Insurance companies must be provided all relevant information by a consumer prior to underwriting the policy. As much as the current health insurance system is flawed, no one can argue against proper underwriting.

What is troubling is the timing and reasoning used by insurers when they rescind coverage. There is ample proof that insurance companies do not begin to investigate a consumer's health history until the person gets sick. In almost every instance, the illness that triggers the investigation has absolutely nothing to do with omissions on the application. It is clear that insurance companies will gladly accept a consumer's premium payments as long as they do not actually get sick.

Outrageous examples of rescissions abound. Individuals who have been diagnosed with cancer have been notified that their coverage is rescinded when they need health care the most. Mothers have been notified that they and their newborn baby have no coverage even after insurers approve prenatal services. Why? The individual with cancer did not list the anti-anxiety medication she was prescribed **once** while in college—more than a decade prior to purchasing coverage. In the other

case, the mother's omission was not stating in her application that she was pregnant—despite the fact that she was only **2 weeks** pregnant when applying. The insurance company denies the fact that the baby had birth defects played any role in its decision to rescind.

These cases are real and are being repeated across California hundreds of times a year. In fact, insurance companies have settled with either regulatory agencies or the courts to re-enroll thousands and thousands of individuals and their families. Yet even after multi-million dollar settlements by every major insurer in California, the practice of rescission is still left to the discretion of the insurance company.

California cannot take a wait and see approach while Washington decides what it will do with health care reform. Regulation is needed to protect patients who are victims of these deceitful practices.

Earlier this summer, top executives of three national insurers, United Healthcare's Golden Rule Insurance Co., Assurant Health, and Wellpoint, Inc., appeared at a congressional hearing to say that they will not confine the cancellations to proven intentional fraud on the part of the policyholder. At the hearing, the three companies disclosed that they canceled the coverage of more than 20,000 people, which allowed the insurers to avoid payment of more than $300 million in claims over a five-year period.

In addition, in a recent court case in Santa Ana Superior Court we learned that some insurance companies have devoted entire departments to handling rescissions. These departments look at patients' medical records going back decades to seek any details that were not disclosed on the patient's applications for coverage. These records are then used against patients.

In 2007, several major health insurance companies announced their support for external review (by an entity of their choosing) of their decisions to rescind policies. Since then, the Department of Managed Health Care restored coverage for 1,092 Kaiser Permanente consumers and 85 Health Net consumers due to unfair rescissions. In addition, Blue Shield was cited for the rescission of 1,262 consumers over four years and the Insurance Commissioner initially proposed $12.6 million in fines that were never imposed.

Because rescission is effectively the death penalty for coverage, making subsequent attempts to gain coverage nearly impossible, even these actions by regulators never make consumers whole. We must always remember that health insurance companies are in the business of caring for human beings, not making widgets. Cutting corners for the bottom line hurts people, often irrevocably.

For the past two years, I have carried legislation in our State Capitol to prevent wrongful rescissions by insurance companies. This measure will protect consumers from being stranded by their healthcare provider when they need coverage the most. Assembly Bill 2 was introduced to address the growing criticism of insurers by physicians, patients and healthcare advocates. I am proud to partner with the California Medical Association (with the support of Consumer Attorneys of California) in our battle against insurance companies.

AB 2 will create protections for policyholders by requiring the approval of state regulators before carriers can drop policyholders for any reason other than nonpayment of their premiums. AB 2 will

require insurers to get approval from the Department of Managed Health Care ("DMHC") or the California Department of Insurance ("CDI") prior to rescinding a policy. This legislation allows the proper regulator to oversee insurers' rescissions on a case-by-case basis.

Additionally, AB 2 will adopt and implement written medical underwriting policies and procedures to ensure that the information on the application and any materials submitted with the application are accurate and complete. This is how underwriting should work. AB 2 also maintains the consumer's coverage while the regulatory review takes place to minimize the incentive for rescission.

AB 2 has faced strong opposition from the insurance industry. While they send out press releases supporting independent review, they are actively working to defeat the bill that will do just that. Their primary focus of attack has been on the standard to be used before lawful rescission can take place.

My bill calls for a common sense and fair standard: did the consumer withhold information that they knew would impact their ability to receive coverage? Insurers claim this standard is unreasonable.

In the much anticipated *Hailey vs. Blue Shield* ruling involving rescission, this intentional standard was put to the test and the insurer prevailed. While the insurer won based on the facts of the case, there is little acknowledgment of the standard that the court utilized for lawful rescission. The *Hailey* court ruling proves that insurers can meet the intentional misrepresentation standard imposed by AB 2.

As Consumer Watchdog described AB 2: "This standard strikes the appropriate balance between patients and insurance companies…Without AB 2, insurers will continue to rescind coverage even if patients honestly filled out their application for coverage." Calling AB 2 an historic bill, Consumer Attorneys of California determined that my bill "will stop gotcha rescissions and ensure honest Californians keep their coverage when they need it most."

Until we tackle the horrendous stigma of "pre-existing conditions" and the ability of health insurers to deny coverage to consumers to avoid health care costs, we need to protect those who have been approved for coverage and make sure that their health care will not be taken away at their most vulnerable moment.