DEPARTMENT OF MANAGED HEALTH CARE
CALIFORNIA HMO HELP CENTER
DIVISION OF PLAN SURVEYS

FINAL REPORT

NON-ROUTINE MEDICAL SURVEY

OF

BLUE CROSS OF CALIFORNIA

A FULL SERVICE HEALTH PLAN

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Final Report of a Non-Routine Medical Survey
Blue Cross of California
A Full-Service Health Plan

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EXECUTIVE SUMMARY

The Department of Managed Health Care (the "Department") conducted a non-routine medical survey of Blue Cross of California (the "Plan" or "BCC") from May 15, 2006 to July 7, 2006, pursuant to section 1380 et al. of the Knox-Keene Health Care Service Plan Act of 1975 (the "Act" or "Knox-Keene"). The survey was conducted to evaluate the Plan's compliance with section 1389.3 of the Act. The Department assessed the processes subject to section 1389.3 relating to enrollment, underwriting, claims handling and rescission determinations for enrollees covered under BCC's individual health care plans.

Health and Safety Code section 1389.3 provides:

> No health care service plan shall engage in the practice of post-claims underwriting. For the purpose of this section, "post-claims underwriting" means the rescinding, canceling, or limiting of a plan contract due to the plan's failure to complete medical underwriting and resolve all reasonable questions arising from the written information submitted on or with an application before issuing the plan's contract. This section shall not limit a plan's remedies upon a showing of willful misrepresentation.

Background
In 2006, the Department began investigating BCC's business application of Section 1389.3 by evaluating a number of complaints filed with the Department's HMO Help Center involving rescission of individual coverage. Subsequently, ten enrollees with BCC's individual medical coverage filed lawsuits in a Los Angeles County court alleging that BCC rescinded coverage after discovering the enrollees needed expensive medical care. The enrollees contend the Plan uses a confusing and ambiguous medical history questionnaire in an effort to trick applicants into making mistakes that the Plan can use later to cancel their policies.

On April 28, 2006, the Department notified the Plan of its intent to conduct an on-site, non-routine survey which would include, but was not limited to, a thorough review of the Plan's pre-enrollment underwriting and post-enrollment rescission practices and the review of case files of enrollees whose coverage was rescinded during the period of January 2004 to March 2006.

Survey Methodology
The Department assessed the Plan's compliance with section 1389.3 based on the following: (a) interviews with Plan management, staff and Counsel; (b) a review of key documents such as policies, procedures, underwriting guidelines and computer programs; and (c) a detailed review of the case files of 90 enrollees for whom coverage was rescinded based on an assertion by the Plan that the enrollee provided false, misleading or incomplete information on the application forms and associated materials.

Survey Results

Deficiencies

The Department identified two compliance deficiencies. Each deficiency indicates an element of non-compliance with the requirements of section 1389.3 of the Act.

Deficiency #1: The Plan does not consistently complete pre-enrollment medical underwriting or resolve all reasonable questions arising from the written information submitted on or with an application prior to issuing an individual enrollment contract.

Supporting evidence for this deficiency included:

- In 39 of 90 case files, the Plan did not conduct a thorough and complete pre-enrollment investigation before issuing coverage. The files lacked evidence of Plan investigation into the nature and severity of injuries reported on the application or follow-up with applicants on conflicting, confusing, missing or erroneous application responses.

- In 36 of 90 case files, the Plan did not thoroughly assess and analyze information provided on or with the application or follow up on missing information. For example, the underwriting guidelines require the Plan to investigate physician visits on applications where the date or other information was missing. The files evidenced a lack of investigation into missing information.

- In 36 of 90 case files, the Plan's coverage decisions did not conform to Plan underwriting guidelines (e.g., did not consistently review enrollees' previous claims in cases where the applicant indicated previous Plan coverage).

Deficiency #2: 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.

Supporting evidence for this deficiency included:

- In all 90 case files, there was no evidence the Plan, before rescinding coverage, investigated or established that the applicant's omission/misrepresentation was willful.

- The survey team identified eight cases in which evidence suggested no willful misrepresentation or omission occurred on the part of the applicant prior to rescission.

- Plan staff represented to the Department that decisions to rescind coverage are based solely on information from the medical records with no effort to address whether a willful misrepresentation occurred.

Analysis
The impact of these compliance deficiencies is significant on both enrollees and health care providers. First, post-claims underwriting is prohibited by law in the unambiguous language of section 1389.3. When a Plan fails to complete medical underwriting and resolve all reasonable questions arising from the application or conduct pre-enrollment medical underwriting, but later rescinds coverage based on a discrepancy identified through "post-enrollment" claims submission, the Plan has engaged in post-claims underwriting in violation of the Act.

Second, rescission of coverage is the remedy available to the Plan based on a showing that the enrollee willfully misrepresented material information on the application. The Plan's Evidence of Coverage specifies that the policy may be rescinded only for "intentional misrepresentation." Consequently, the burden of establishing a prima facie case for rescission is on the insurer, who must prove the grounds relied upon for rescission. The burden of proof goes beyond a discrepancy between the application and information noted in subsequent medical claims review. The Plan is obligated to prove the enrollee's intentional misrepresentation. The Department seeks to ensure plans act in conformity with their Evidences of Coverage and meet this burden of proof. A rescission of health care coverage is a harsh result for enrollees; creating the potential for substantial health consequences as well as personal financial hardship for charges thought to be authorized and covered by the Plan.

Conclusion
The Department found the Plan to be in violation of section 1389.3.

A COPY OF THIS REPORT HAS BEEN REFERRED TO THE DEPARTMENT'S OFFICE OF ENFORCEMENT.

I. OVERVIEW OF PLAN PROCESSES

The retrospective review and rescission process of BCC can be divided into four stages, which are described in more detail as follows:

1. Application
2. Initial Underwriting
3. Identification of Claims for Review
4. Medical Claims Review and Rescission

1. Application
Applicants who desire to purchase individual medical coverage (subject to Department regulation) or BCC Life and Health coverage (subject to regulation by the Department of Insurance) are required to complete an Enrollee Application Form ("Form"). The Form is eight pages long and is used for medical, dental, and term life insurance coverage, as well as for gathering information to determine whether the applicant is eligible for coverage under the Health Insurance Portability and Accountability Act of 1996.

The Form includes a three-page Medical History Questionnaire, sections 6A through 6E. Section 6A is a set of 20 "yes" or "no" questions for males and females on 14 bodily systems, and six incident-related questions that cover virtually any possible illness, diagnosis, or service. The information collected includes current and past conditions (if any), weight, height, social history (tobacco, illicit drug, or alcohol use), and medical treatments.

The application process may include involvement of and/or interaction with a broker or agent. Interviews with Plan staff indicate that an estimated 8,000 brokers and agents sell BCC individual products. Plan staff stated that brokers/agents are typically supplied with general underwriting guidelines to assist in pre-qualifying applicants for insurability and advising them of likely final rates based on their health history. Brokers/agents are compensated based upon a percentage of the premium which is adjusted should an application be rescinded. Plan staff also stated that brokers/agents generally receive training and some have undergone a special certification process.

2. Initial Underwriting
The underwriting process includes an evaluation of the application for completeness; gathering of additional information or clarification as needed; review of the health information on the application; implementation of the Plan's underwriting guidelines; review of prior claims history (if available); acceptance or declination of the application; and assignment of risk level and associated payment rates.

The Plan employs underwriters with underwriting experience. Medical or clinical experience or background is not a required qualification. Underwriters receive no commissions or bonuses, nor any incentives for the number of applications processed or coverage rescissions. Upon hire, all underwriters undergo an eight-week training program. One hundred percent of underwriter's work is audited until he/she reaches 97 percent quality.

The Plan has policies in place that enable the use of multiple sources of medical history information (e.g., applicant, primary care physician,) for underwriting. It also has policies for timely processing. Forms are processed through a data entry function that screens for acceptable answers to all questions. If the Form is not received electronically, it is scanned for archival purposes. The electronic version of the scanned Form is then available to the underwriter for review.

The Plan relies on the information provided by the enrollee on the Medical History Questionnaire and previous Plan claims history (if any) to determine whether to accept an applicant and what rates to apply. Past claims history (if any) and attending physician statement (if required) may also be obtained and used to estimate the underwriting risk. Plan policies require contact with applicants or the brokers by telephone for missing or questionable information noted in the Form.

3. Identification of Claims for Review

Following enrollment, the Plan monitors submitted claims to detect the presence of diagnoses likely to indicate pre-existing conditions. The review occurs for all enrollees, including enrollees with a pre-existing condition waiver. The review identifies and investigates any potential pre-existing condition not disclosed at the time of enrollment. The Plan’s policy states that if an applicant discloses a condition on the application, and the applicant is underwritten and enrollment approved, the Plan will not later limit or deny coverage related to the admission of that condition.

The Plan identifies cases for review primarily through automated examination of diagnoses and services on claims submitted for payment. To prepare for the on-site survey, the Plan submitted criteria for claims review based on potential pre-existing conditions and rescission. The criteria identify diagnoses and medical services from the enrollment date and likely to indicate a pre-existing condition (e.g., pregnancy, chronic conditions). The Plan reviews claims for outpatient and inpatient services. The Plan’s Evidence of Coverage notifies enrollees that policy rescissions may only occur in cases of “intentional misrepresentation.” The EOC permits rescission for services incurred within twenty-four months of the original effective date.

During on-site interviews, the Plan’s staff outlined the current method for automatically identifying claims that need further medical review for possible rescission, and they provided copies of computer programs used for this purpose.[1]

4. Medical Claims Review and Rescission

In a majority of cases, a referral for medical review initiates a request for medical records from the claimant provider. The Plan generates a notification letter to the enrollee which describes the review procedure. A medical review of the claimant provider’s medical records usually includes a medical history that may trigger additional requests to the enrollee for additional provider names and contact information in order to obtain additional medical records. The medical claims review may date back as far as ten years prior to the application date.

[1] The Plan's initial underwriting and claims review criteria produced to the Department in response to a subpoena for documents were dated and no longer in practice.

A second notice is mailed to the enrollee advising of potential appeal rights and the consequences of the rescission if it becomes the final decision. In some circumstances, the enrollee receives the second notice and the rescission decision in close proximity.

The Plan generally makes decisions to approve or rescind in a timely manner. Communications to enrollees about the reasons for rescission contain excerpts from the questionnaire and the medical record, and are generally clear.

II. SURVEY HISTORY

The table below is a schedule of survey activities conducted by the Department at the Plan in the past three years.

TABLE 1

SURVEY ACTIVITY	DATE
2002 Routine Survey On-Site Visit	August 26–30, 2002
2002 Preliminary Report	November 14, 2002
Final Report for 2003 Routine Survey	February 18, 2003
Follow-Up Report Issued to Plan	August 4, 2004
2005 Routine Survey On-Site Visit	August 22–26, 2005
2005 Preliminary Report Issued to Plan	November 17, 2005
Final Report for 2005 Routine Survey	April 5, 2006
Non-Routine Survey On-Site Visits	May 15, 2006 – July 7, 2006
Preliminary Report for 2006 Non-Routine Survey	August 21, 2006
Final Report for 2006 Non-Routine Survey	February 28, 2007

III. DISCUSSION OF SURVEY DEFICIENCIES

Section 1389.3 of Knox Keene expressly prohibits post-claims underwriting and requires each health plan to "complete all medical underwriting and resolve all reasonable questions arising from the written information submitted on or with an application before issuing the plan contract." The section does not limit a plan's remedies upon "a showing of willful misrepresentation."

Plans must conduct a thorough pre-enrollment underwriting review in order to make informed coverage decisions. A plan that fails to perform a diligent pre-enrollment assessment and instead defers its medical underwriting until after it receives medical claims may be engaging in prohibited post-claims underwriting, determining the degree of coverage based on medical claims received after coverage is approved.

Section 1389.3 (a) requires plans to conduct thorough pre-enrollment underwriting and (b) protects enrollees from unjustified rescissions by requiring that plans demonstrate a showing of willful misrepresentation on the part of the enrollee before the plan rescinds coverage, a burden set forth in the statute.

The Department identified two deficiencies resulting from this non-routine medical survey. Each deficiency indicates an element of non-compliance with the requirements of section 1389.3 of the Act. (See Table 2.)

TABLE 2

SUMMARY OF SURVEY DEFICIENCIES		
#	**DEFICIENCY STATEMENT**	**STATUS**
1	**The Plan does not consistently complete medical underwriting and resolve all reasonable questions arising from the written information submitted on or with an application prior to issuing an individual enrollment contract**. [Section 1389.3]	**NOT CORRECTED**
2	**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**. [Section 1389.3]	**NOT CORRECTED**

The following discussion describes the conditions and implications of each deficiency.

POST-CLAIMS UNDERWRITING

Deficiency #1: **The Plan does not consistently complete medical underwriting and resolve all reasonable questions arising from the written information submitted on or with an application prior to issuing an individual enrollment contract.**

Criteria: Section 1389.3

Condition: In 39 of 90 case files, the Plan did not conduct a thorough and complete pre-enrollment underwriting investigation prior to approving the application. The files lacked evidence of Plan investigation into the nature and severity of injuries reported on the application or follow-up with applicants on conflicting, confusing, missing or erroneous application responses. However, in several cases, the Plan later rescinded coverage based on a finding of non-disclosure which was triggered by and later identified through claims review.

In 36 of 90 case files, the Plan did not consistently conduct a full analysis or follow-up on medical information provided on or with the coverage application to resolve all reasonable questions arising from the application. The Plan did not consistently and thoroughly investigate the nature and severity of injuries or conditions reported by the applicant on various sections of the application before approving coverage. For example, the underwriting guidelines require the Plan to investigate physician visits on applications where the date or other information was missing. The files evidenced a lack of investigation into missing information.

In 36 of 90 case files reviewed, the Plan failed to comply with the Plan's own underwriting guidelines (e.g., did not consistently review enrollees' previous claims in cases where the applicant indicated previous Plan coverage).

The Department reviewed 90 case files of enrollees whose individual plan coverage was rescinded between January 2004 and March 2006 and found the following:

TABLE 3

AREAS OF NON-COMPLIANCE WITH PRE-ENROLLMENT UNDERWRITING STANDARDS

FILE TYPE	# OF FILES REVIEWED	ELEMENT	# COMPLIANT	# DEFICIENT
Cases reviewed by Plan for possible non-disclosure of pre-existing condition, coverage rescinded	90	Thorough and appropriate pre-enrollment underwriting process	51	39
		Adequate assessment and analysis of information	54	36
		Acceptance in conformity with the Plan's underwriting guidelines	54	36

Implications: The Plan's failure to consistently complete medical underwriting and to resolve all reasonable questions arising from the written information submitted on or with an application before issuing the Plan's coverage but later rescinding coverage based on medical claims review is indicative of prohibited post-claims underwriting.

Rescinding health care coverage is a serious action, placing the enrollee at financial risk for the full amount of billed medical charges and potentially rendering the enrollee uninsurable. The pre-enrollment assessment must be detailed and comprehensive to support the Plan's coverage decision and avoid problems after services have been rendered to the enrollee. Rescinding coverage creates a series of problems for the enrollee in receiving necessary care, with the potential for a significant threat to the enrollee's health status. Additionally, providers may incur financial losses due to non-payment of charges by the Plan and enrollee.

Corrective Action: Within 30 days following notice to a plan of a deficiency, the plan is required to file a written statement with the Department (Rule 1300.80.10), signed by an officer of the plan, describing any actions that have been taken to correct the deficiency. For those deficiencies that may reasonably be expected to require a longer period than 30 days to remedy, a plan may submit evidence that the plan has initiated remedial action to achieve an acceptable level of compliance.

Plan's Compliance Effort: The Plan respectfully disputes the Department's findings of any deficiencies. The Plan, however, responded within the 30 day timeframe, reporting the implementation of significant changes in the initial underwriting and rescission review process.

Department's Finding Concerning Plan's Compliance Effort:

STATUS: NOT CORRECTED

The Department found the Plan made a significant effort to address the deficiency. However, this deficiency has been adjudged to be of a nature to require a period longer than 30 days to remedy.

The Plan asserts implementation of specific improvements evidenced through a signed statement accompanying the response and submission of draft documents. The Department accepts this as evidence that the plan has initiated remedial action and is on the way to achieving acceptable levels of compliance. The Department, however, will conduct a follow-up survey no later than 18 months following the release of the final report to verify the Plan's efforts and confirm correction of this deficiency.

Deficiency #2: **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.**

Criteria: Section 1389.3

Condition: Section 1389.3 requires a health care service plan to demonstrate "a showing of willful misrepresentation" on the part of the applicant before rescinding health care coverage.

In the event of a discrepancy, comparing the pre-enrollment application with claims submitted after coverage is approved, the Plan's remedies are not limited, which may include rescinding coverage, if the Plan performed proper underwriting and can show willful misrepresentation or the enrollee acted with intent to deceive.

In the majority of case files, no evidence was found to substantiate that the Plan met its burden to prove intent or willful misrepresentation on the part of the enrollee before coverage was rescinded.

In many cases, the Plan collected additional medical and member information; however, no evidence demonstrated the Plan confirmed the enrollee's intent, beyond merely noting the existence of a discrepancy between enrollment form and subsequent claims submission. The Plan rescinded coverage relying only on the discrepant information as an indicator of the enrollee's intent.

TABLE 4

AREAS OF NON-COMPLIANCE WITH POST-ENROLLMENT RESCISSION ACTIVITY STANDARDS

FILE TYPE	# OF FILES REVIEWED	ELEMENT	# COMPLIANT	# DEFICIENT
Cases reviewed by Plan for possible non-disclosure of pre-existing condition, coverage rescinded	90	Information gathered from enrollee (using letter code MR 26)	46	44
		Determination made in conformity with the Plan's own underwriting guidelines	87	3
		Actively investigate whether the omission was willful	0	90

Statements made by Plan officials and staff to the Department and corroborated by file review indicated that underwriters rely on evidence noted in the medical record associated with a discrepancy on the Health Questionnaire. In 44 of 90 cases, the Plan relied exclusively on the discrepancy as the basis for coverage rescission.

In cases where the Plan received additional information from the enrollee or the enrollee's physician, providing an explanation for a discrepancy on the application, the Plan asserted the information was considered, however, the Survey Team found no evidence that the Plan considered the additional information in the decision-making process before rescinding coverage.

If medical records happen to be inaccurate, enrollees are encouraged to contact the provider and request a correction of the medical record and submit the corrected record to the Plan.

The Department noted on the 1/04 version of the Application Form, page 7, the Plan added the word "intentional" in the rescission paragraph, notifying the enrollee of the grounds for rescission. However, during the retrospective claims review, the Survey Team found no evidence the Plan determines the intent of the enrollee to commit willful misrepresentation before rescinding coverage.

Implications: The burden of proof referenced in the statute requires the Plan to rely on not only discrepant information, but to establish the enrollee intended to provide misleading or false information at the time of application. This is a fact-intensive analysis, requiring the Plan to deliberate based on information from the enrollee, medical records and providers.

Corrective Action: Within 30 days following notice to a plan of a deficiency, the plan is required to file a written statement with the Department (Rule 1300.80.10), signed by an officer of the plan, describing any actions that have been taken to correct the deficiency. For those deficiencies that may reasonably be expected to require a longer period than 30 days to remedy, a plan may submit evidence that the plan has initiated remedial action to achieve an acceptable level of compliance.

Plan's Compliance Effort: The Plan respectfully disputes the Department's findings of any deficiencies. The Plan, however, responded within the 30 day timeframe, reporting the implementation of significant changes in the initial underwriting and rescission review process.

Department's Finding Concerning Plan's Compliance Effort:

STATUS: NOT CORRECTED

The Department finds the Plan's corrective action plan non-responsive to this deficiency. A description of the Plan's process to determine willful misrepresentation is absent in all draft documents submitted to support correction of this deficiency.

The draft Individual Medical Underwriting policy states that, "retroaction cannot be applied where the information otherwise justifying rescission would have been uncovered had the initial underwriter completed medical underwriting and resolved all reasonable questions. The Department maintains the Plan must show willful misrepresentation on the part of the enrollee prior to rescission of coverage.

The Plan has neither established a consistent policy or operation that effectively determines willful misrepresentation prior to rescission.

V. SURVEY CONCLUSION

As a result of this non-routine medical survey, the Department determined the Plan violates Section 1389.3 of the Act. The Department will conduct a follow-up survey no later than 18 months following the release of the final report to verify the plan's efforts and confirm correction of these deficiencies.

Additional portions of the Plan's response have been granted confidential treatment pursuant to Section 1007 of Title 28, Chapter 1, of the California Code of Regulations. They are contained in a separate confidential file. In addition the Department, in an effort to ensure that patients are protected from inadvertent disclosure of personal medical information, has redacted references to individual complaints and patient specific information from this Report.

A P P E N D I X A

A. THE NON-ROUTINE SURVEY METHODOLOGY

NON-ROUTINE SURVEY METHODOLOGY

Section 1389.3 of Knox Keene expressly prohibits post-claims underwriting.

The Department's survey team evaluated Plan processes subject to section 1389.3 of the Act relating to enrollment, underwriting, claims handling, and rescission determinations for enrollees covered under the Plan's individual health care plans. The Department's evaluation included the following activities:

1. Interviews
The Department interviewed Plan management, staff, and Counsel to obtain a thorough understanding of Plan policies and procedures related to underwriting, retrospective review case identification, and rescission activities. Interviews were conducted periodically during case file review to clarify plan processes, especially when inconsistencies were identified between actual procedures and written policies.

2. Document Review
The Department reviewed policies and written procedures that described the Plan's underwriting and retrospective review activities.[2] The Department also reviewed the extensive underwriting guidelines that the Plan submitted. These guidelines describe the processes and criteria by which the Plan evaluates an applicant for health care coverage and assigns risk levels and associated payment rates. Related correspondence and computer programs used for identification of cases for retrospective review were also reviewed.

3. Case File Review
The Department requested a log of cases of retro-cancellation or rescission of individual plan coverage where the decision to rescind occurred January 2004 through March 2006. The Department randomly selected a group of 500 files from the log. A subset of 100 files was selected for initial review from the 500 files; with the remaining 400 held in abeyance should additional reviews be needed. Ten case files were eliminated from the sample because these enrollees are covered by Blue Cross Life & Insurance Co., an entity under the jurisdiction of the Department of Insurance. This action resulted in a final sample size of 90 files for initial review.

To facilitate the review process, the Department asked the Plan to compile the following enrollee-specific documents and materials for each one of the 500 cases selected:

1. Completed enrollment application, including attachment(s) and related instructions;
2. Completed Medical History Questionnaire, including attachment(s) and associated instructions;

[2] The Plan's initial criteria produced to the Department in response to a subpoena for documents were dated and no longer in practice.

3. Applicable evidence of coverage and terms of agreement/contract, including all limitations and exclusions;
4. Effective date of enrollment;
5. Termination notice;
6. Effective date of termination;
7. Documents the Plan relied on for rescinding coverage, including all medical records, claims, and correspondence;
8. Utilization management case files (electronic and other forms), including authorizations, denials, etc., since enrollment;
9. Case management notes, if any;
10. All communications between the Plan and the enrollee (and/or his/her representatives) whether written, by telephone, e-mail or FAX;
11. Any and all documents collected and utilized by the Plan to determine the policy cancellation, such as the enrollee's medical records for the time period prior to his/her enrollment;
12. All enrollee complaint/grievance related correspondence, including telephone log information.

The Department reviewed each of the 90 files against the documents and other related materials provided by the Plan. The Department developed a standardized file review worksheet for the purpose of reviewing these case files. The worksheet collected descriptive data on the case (e.g., enrollment and rescission dates, health issues noted on the application, rescission reason as cited by the Plan) and assessed Plan performance on key standards related to pre-enrollment underwriting activities and post-enrollment rescission process activities. These key performance standards included:

Pre-enrollment underwriting activities

- Did evidence document adequate assessment and analysis of the information gathered prior to the coverage decision date?
- Did the Plan complete medical underwriting in concert with Plan policies and procedures and resolve all reasonable questions arising from the written information submitted on or with the application before issuing a contract?
- Did the decision to accept and the level of risk assigned to the enrollee for coverage conform to the Plan's own underwriting guidelines?

Post-enrollment rescission process activities

- Did evidence document follow-up with the enrollee to gather further information regarding the omission?
- Did evidence document follow-up with physicians to gather further information regarding the omission?
- Did documentation demonstrate appropriate Plan review and analysis of the alleged omission/misrepresentation prior to "rescinding" of coverage?
- Did evidence document that the enrollee was notified of the decision to "revoke" within a reasonable timeframe?
- Was the enrollee given an opportunity to appeal verbally or in writing?
- Was the reason cited by the Plan in the notification letter clear and easily understood?

- Was the decision to rescind in conformity with the Plan's own underwriting guidelines?
- Did the Plan solicit a written explanation from the enrollee of whether the omission was willful, or if not willful, why the information was omitted?
- Did the Plan specifically address/consider whether the omission was willful?
- Based on the available evidence, was the enrollee aware that the information was false?

The Department used four experienced surveyors/reviewers to perform the case file reviews. The case reviewers included two physicians (Lawrence Ikeda, MD, and Erick Davis, MD, MPH, MBA), both of whom have extensive clinical experience, managed care administration experience, and experience performing utilization management and quality management review for the Department's routine and non-routine medical surveys. The team also included a registered nurse (Rose Leidl, RN) with critical care nursing background and extensive managed care and regulatory survey experience. Finally, to provide underwriting and financial expertise, the team included a non-clinical managed care professional with extensive experience managing HMOs as a CEO and CFO (Michael Fleck, MBA).

If a file was found to be non-compliant by the initial case reviewer, it was passed to another case reviewer for a second review. A file was deemed to be non-compliant on a key review standard only if two case reviewers independently confirmed it.

A determination that the alleged non-disclosure was not willful would suggest that coverage should not have been revoked. Such a finding would indicate a significant deficiency. For this reason, cases in which it appeared that the alleged false representation or non-disclosure was *not* willful were passed to a third case reviewer for further consideration. Therefore, in order to determine that section 1389.3 was violated, at least three case reviewers from the four-member case review team must have concluded that no willful misrepresentation or omission occurred.

The Department also reviewed ten files for cases that were reviewed by the Plan for possible failure of the enrollee to disclose a pre-existing condition, but for which a determination to rescind coverage did *not* occur. These cases were reviewed to identify any inconsistencies in the Plan's application of its review processes and criteria that may have resulted in the decision not to rescind. The Department found inconsistencies in the underwriters' application of review procedures and underwriting criteria.

A P P E N D I X B

B. APPLICABLE STATUTES AND REGULATIONS

The following are the specific citations used in this report in identifying the deficiency (ies).

Deficiency #1: **The Plan does not consistently complete medical underwriting and resolve all reasonable questions arising from the written information submitted on or with an application prior to issuing an individual enrollment contract.**

Citation:

§ 1389.3. Post claims underwriting

No health care service plan shall engage in the practice of post-claims underwriting. For purposes of this section, "post-claims underwriting" means the rescinding, canceling, or limiting of a plan contract due to the plan's failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the plan contract. This section shall not limit a plan's remedies upon a showing of willful misrepresentation.

Deficiency #2: **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.**

Citation:

§ 1389.3. Post claims underwriting

No health care service plan shall engage in the practice of post-claims underwriting. For purposes of this section, "post-claims underwriting" means the rescinding, canceling, or limiting of a plan contract due to the plan's failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the plan contract. This section shall not limit a plan's remedies upon a showing of willful misrepresentation.

PLANS APPENDED STATEMENT

The Plan has appended its response to this Report as authorized under section 1382(d) of the Act. To view that appended plan response, please access the link below:

Final Report Blue Cross of California Post Claims Underwriting Non-routine Survey