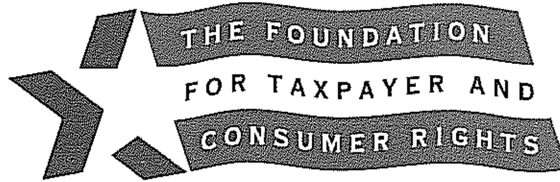

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February 14, 2008

Ms. Cindy Ehnes
Director
Department of Managed Health Care
980 Ninth Street, Suite 500
Sacramento, CA 95814-2725

Dear Ms. Ehnes,

We are writing to urge you to take swift action to end Blue Cross' practice of conscripting doctors to become double agents and turn against the very patients they have promised to serve. We urge you to advise all health plans that they must refrain from forwarding a member's enrollment application to their treating physician, and asking that physician to utilize administrative or financial judgment about coverage issues that are typically functions of underwriters and utilization reviewers.

The *Los Angeles Times* has reported that Blue Cross has sent thousands of letters a month to doctors for years urging them to compare policy applications by patients to their medical files, doing the work of insurance underwriters to help Blue Cross illegally terminate insurance policies. This is a violation of California law including Health & Safety Code § 1367 (g) and others.

Blue Cross' announced voluntary cessation of the practice should not stay your hand. Absent swift and final action by you, Blue Cross will likely return to the profitable practice in the future, and other insurers may adopt it if they have not done so already.

Not only do Blue Cross' actions have a chilling effect on the doctor-patient relationship, they violate the legal and social framework of our health care system—the principle that medical decisions are to be rendered unhindered by fiscal and administrative concerns.

Blue Cross has reportedly sent patients' applications to their doctors urging the doctors to scrutinize the documents and compare them to a patient's current medical needs and conditions – a process know as "utilization review" – and to report any potential "omissions" to Blue Cross to be used as a basis for rescinding or canceling the insurance policy.

The letter obliquely reminds the HMO physicians, who are paid a set rate no matter how much care they provide, of his or her financial incentive to dump sick patients: "The purpose of providing you with this copy [of the patient's insurance application] is to help you identify members who have failed to disclose medical conditions on their applications that may be considered pre-existing."

Simply put, doctors have a financial incentive to team up with insurers to drop potentially sicker patients by fudging their analysis of which health conditions "may be considered pre-existing" – those that *may have* developed prior to the patient getting coverage. Those physicians may also fear reprisals if they refuse to cooperate.

Blue Cross, which has been embroiled in far-reaching scandal for illegally canceling insurance polices when patients get sick, may later use that information to argue that a patient making a substantial claim lied on his or her application, even if the claim has no relationship to the purported omission, as a basis for retroactively canceling coverage.

Your Authority

Health & Safety Code §§ 1341(c), 1341.8, 1341.10, 1357.17, and others require, you, as director of the Department of Managed Health Care, to exercise all powers necessary to enforce the law:

> The director shall be responsible for the performance of all duties, the exercise of all powers and jurisdiction, and the assumption and discharge of all responsibilities vested by law in the department. The director has and may exercise all powers necessary or convenient ...

Health & Safety Code § 1341(c).

Statutory Provisions Barring the Practice

The legislature has contemplated the very threat to patient health represented here and has included several provisions giving you broad authority to act. First, the legislature has endeavored to preserve the keystones of health care, such as the sanctity of the doctor-patient relationship, from the very distrust, uncertainty and fear that this practice engenders.

> It is the intent and purpose of the Legislature to promote the delivery and the quality of health and medical care to the people of the State of California who enroll in, or subscribe for the services rendered by, a health care service plan or specialized health care service plan by accomplishing all of the following:

(a) Ensuring the continued role of the professional as the determiner of the patient's health needs which fosters the traditional relationship of trust and confidence between the patient and the professional.

Health & Safety Code §1342.

In addition, the legislature has made it clear that medical decisions are to be independent of fiscal and administrative concerns. In this case, the activity pushed on doctors by insurers is both fiscal and administrative. In fact, the letter from Blue Cross is addressed to "utilization review management." On that point, the law states:

> The plan shall have the organizational and administrative capacity to provide services to subscribers and enrollees. The plan shall be able to demonstrate to the department that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management.

Health & Safety Code § 1367 (g).

Further, state law requires health plans to file with the Department a description of any policies and procedures related to "economic profiling" utilized by the plan and its medical groups and individual practice associations.

> The filing shall also indicate in what manner, if any, the economic profiling system being used takes into consideration risk adjustments that reflect case mix, type and severity of patient illness, age of patients, and other enrollee characteristics that may account for higher or lower than expected costs or utilization of services. The filing shall also indicate how the economic profiling activities avoid being in conflict with subdivision (g) of Section 1367, which requires each plan to demonstrate that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management.

Health & Safety Code § 1367.02. Such profiling information may provide the Department with information about the types of punitive actions Blue Cross takes against physicians who refuse to assist Blue Cross in its efforts to cancel sicker patients utilizing more medical care.

Lastly, this practice is yet another example of Blue Cross' violation of a statutory ban on "postclaim" underwriting – the practice of canceling coverage after a patient gets sick. Insurance companies are required to conduct underwriting prior to issuing coverage. If they fail to do so, coverage may not be canceled unless the insurer can show that a patient willfully misrepresented their health condition on the application for coverage. The law states:

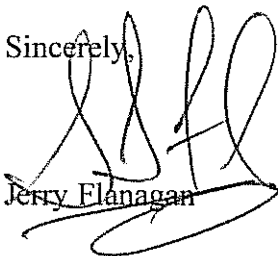
> No health care service plan shall engage in the practice of postclaims underwriting. For purposes of this section, "postclaims underwriting" means the rescinding, canceling, or limiting of a plan contract due to the plan's failure to complete medical underwriting and resolve all reasonable questions 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.

Health & Safety Code § 1389.3.

Here, we have a classic example of preparation for post-claims underwriting. Instead of insurance underwriters conducting the reviews after claims for coverage have been submitted, Blue Cross has outsourced the activity, pre-claim but after issuance, to doctors.

Blue Cross' very act of recruiting doctors to scour enrollment applications and medical records for conditions that "may be considered pre-existing" is evidence that the company failed to complete adequate underwriting, including reviewing a patient's medical records itself, prior to issuing coverage. The company instead uses a doctor who has examined the unknowing patient in a relationship of trust to predict possible future losses, then holds that card to be played in the event of a claim.

Sincerely,



Jerry Flanagan