

State works to protect consumers from having health coverage pulled

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Wednesday, October 24, 2007

Ten months after Mark and Rosellen Robison's 9-year-old son had minor surgery in 2004, the Santa Rosa family's health insurer, Blue Cross of California, accused the couple of lying on their health application and revoked their coverage.

The Robisons, who sued Blue Cross earlier this month, have been left with \$14,000 in medical bills and slim to no chance of finding new coverage.

"They can pull the rug out from under you at any given time," said Rosellen Robison. "That is so unfair."

Consumers applying for individual health policies - as opposed to group coverage - have to fill out an application detailing their medical history. Some, like the Robisons, find that after they incur medical bills, insurers look back over their health history and use discrepancies in applications as a reason to yank their coverage.

Rosellen Robison said she was asked no questions that might have prompted her to disclose a minor congenital anomaly in her son, Tylor, that she believed would not require treatment. But doctors later determined he needed surgery.

Health insurers say they need to protect themselves and honest policyholders from people who lie or omit facts about their health history in order to get covered. They say they generally have to resort to such tactics in about 1 percent or less of new enrollments.

But consumers say the questions are vague and confusing and require them to remember details of their medical history they may have forgotten or don't realize are significant. Trial lawyers represent potentially thousands of California policyholders who claim they were unfairly dumped.

On Tuesday, state health care regulators released a draft of long-awaited regulations designed to clarify how and when a health insurer can rescind a member's policy if the company suspects fraud.

Much of the legal wrangling has centered on whether an insurer must prove applicants willfully misrepresented themselves on forms. According to the proposed rules, insurers must determine a member intentionally lied on the application and that inadvertent omissions or misunderstandings should not lead to cancellation of coverage.

The regulations would require insurers to properly review applications and check available medical records before issuing a policy. Insurers also would have to simplify their applications to avoid confusing questions and inform members that their applications are being investigated before dropping their policies.

"Essentially, health plans have done whatever they wanted to," said Cindy Ehnes, director of the Department of Managed Health Care, which regulates the state's health maintenance organizations. "At the end of the day, we owe some fairness to people who have been given coverage and used that coverage when they were sick."

The new rules, which must go through a process that can take several months before being adopted, are part of a larger effort by state regulators to curb what are known as illegal rescissions, or the practice by some insurers of canceling policies without proper cause.

In March, the department fined Blue Cross of California \$1 million for routinely revoking policies without making an effort to determine whether the rescissions were warranted. The department also fined Kaiser \$325,000 for illegally rescinding two members' coverage and continues to investigate Kaiser along with other insurers, including Blue Shield, Health Net and PacifiCare.

William Shernoff, a Claremont (Los Angeles County) attorney who represents California policyholders in a class-action rescission case along with many individual cases, was pleased by the proposed rules.

"This requires insurers to do what many of them had not been doing: to do their medical underwriting up front, not take their money, wait until they get sick and go back and find a loophole," said Shernoff, whose firm represents the Robisons.

Last spring, Blue Cross and plaintiffs' attorneys thought they had reached a tentative settlement on behalf of as many as 6,000 current and former policyholders whose coverage was rescinded since 2001. But that settlement has been on hold while the parties try to negotiate an agreement that involves unpaid medical providers, Shernoff said. He said attorneys also are awaiting a key court decision on a rescission case against Blue Shield of California that may affect future cases.

Insurers, however, were concerned that rules requiring them to prove an applicant intended to lie would make individual insurance more expensive and difficult to get.

"We're concerned a broad willfulness requirement will make it more expensive and complicated for individuals to purchase health coverage," said David Seldin, spokesman for Blue Shield of California.

Christopher Ohman, chief executive of the California Association of Health Plans, said insurers will work with state regulators on any issues they may have with the new rules. "We feel strongly that consumers deserve to be confident in that we will have a fair process that will ensure we keep the cost of fraud out of their premiums," he said.

At least one consumer group is concerned the new regulations still leave too much power in the hands of insurers.

"They leave it up to the plans to investigate, and the insurance company has a financial incentive to deny as many people as possible," said Jerry Flanagan, health advocate for the Foundation for Taxpayer and Consumer

Rights in Santa Monica. He said he would like regulators to play a more active role in mediating rescission disputes.

Blue Cross of California, the insurer accused of being unfair in the Robisons' case, changed its policies in September 2006, clarifying language used in the application to reduce the number of unintentional errors that could lead to a rescission.

According to Rosellen Robison, who filled out the application on behalf of herself, her husband, son and daughter in 2003, she answered all the questions truthfully.

Because the family had Blue Cross before a short lapse in coverage, she assumed the insurer had access to any medical records necessary and past claims data.

Blue Cross spokesman Nick Garcia said the company does not discuss cases in litigation.

Meanwhile, the Robison family has joined the ranks of nearly 7 million Californians and 47 million Americans who do not have health insurance.

Mark Robison is a self-employed real estate loan agent, and his wife a loan processor who also is self-employed. They have tried to get insurance, but feel they have little chance after having their insurance revoked and subsequently suing.

Rosellen Robison said she is nervous about the family being uninsured. Recently, she said, her son wanted to participate in a school activity but it required him to have health insurance.

"We just hope for the best. We do that every single day," Rosellen Robison said. "You can't tell them not to be kids."

Protect your health coverage

Insurers require consumers applying for individual health policies, as opposed to group insurance offered through an employer, to fill out a questionnaire detailing their medical history. Some tips:

Ask questions: If you don't understand a question on a health application and need clarification, call the insurer. Truthfully answer all questions, and don't assume your insurer will check your medical history.

Keep records: Keep copies of all correspondence from the insurer, and take notes during telephone calls. This will help if a dispute arises.

Act quickly: If your coverage is in danger of being revoked, appeal in writing. You might need a letter of support from your health provider. Demand to see any information the plan is relying on to make its decision.

For help: Patients with HMO plans should contact the state Department of Managed Health Care's HMO Help Center at (888) 466-2219. For those with other plans, contact the state Department of Insurance at (800) 927-4357.

Source: Chronicle research