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BLUE CROSS SETTLING PATIENTS' LAWSUITS

The big insurer, accused of illegally canceling some policies, agrees to pay its ex-customers.

Facing the threat of punishment from regulators, Blue Cross of California has agreed to settle more than 70 lawsuits and claims filed by patients who accused the state's largest health insurer of illegally canceling their coverage after they got sick.

The settlements will allow the former policyholders to pay hefty medical bills that they were stuck with after losing their insurance.

Lawyers involved in the cases, who confirmed that they had been resolved, said the dollar amounts of the settlements were confidential.

In exchange for the money, the patients agreed to drop allegations that Blue Cross had terminated their coverage to avoid paying for treatment.

The accords could be part of an effort by Blue Cross to deflect public criticism, mollify regulators and avoid courtroom showdowns, although critics say the insurer still needs to reform its practices.

State regulators have fined Blue Cross in one case of canceled coverage, and more sanctions are expected.

Blue Cross, owned by Indianapolis-based WellPoint Inc., the nation's largest provider of health benefits, maintained that it was following the law. It declined to comment on the suits, saying talks to settle them were confidential.

William Shernoff, a Claremont lawyer representing many of the plaintiffs, said his clients wouldn't have to worry about medical bills ever again.

"Every one of our clients is pleased," he said. "But that's only half the story. The other half of the story is making sure it doesn't happen again and getting the right procedures in place."

The settlements follow a series of Times stories examining the cancellations and the hardships they caused for patients, their families, hospitals and physicians. Among those agreeing to settlements is a Riverside couple, described in a Sept. 17 article, who were forced to put their home up for sale after they were hit with a mountain of medical bills. Another settlement accord involves the family of a 6-year-old Murrieta girl, also described in the article, who was dropped by the insurer in the midst of treatment for a life-threatening tumor in her jaw.

At issue in the suits is individual health insurance, purchased by people who do not have group coverage through an employer or other organization. Unlike with group insurance, an insurer can deny coverage to a person it deems too risky based on the applicant's medical history and answers to a detailed health questionnaire.

The suits accuse Blue Cross of routinely violating state laws prohibiting insurers from canceling coverage unless a policyholder lied to obtain it. The suits allege that the application questionnaires were intentionally vague and confusing and were designed to trap applicants into making innocent mistakes that could later be used as excuses to cancel coverage. Blue Cross, according to the suits, scrutinized questionnaires only after it received a claim for a costly or potentially chronic condition.

At least five other health insurers, including Blue Shield of California, face similar lawsuits filed by customers. In recent weeks, two state agencies that oversee the industry have expanded investigations into the alleged practice. Last month the Department of Managed Health Care issued its first fine — \$200,000 against Blue Cross — after finding that the company improperly revoked a Southern California woman's policy. The amount of the fine was criticized by consumer advocates as insignificant for WellPoint.

It remains unclear whether the proposed settlements would lead to substantial changes in Blue Cross' business practices or state regulations. Some see the accords as a sign that the state's largest health insurer intends to reform its practices. Others view the settlements as a way for the company to sweep the matter under the rug and move on.

"This is a standard way to avoid setting any precedent for future accountability," said Bryan Liang, director of the Institute of Health Law Studies at California Western School of Law in San Diego. Blue Cross "can easily pay off individuals, and those individuals have to take it to move on with their lives and recover from the horrors of having their health insurance taken away."

Blue Cross, like other insurers, contends that it is allowed to drop policyholders regardless of whether medical history omissions are intentional. The industry says the power to revoke policies is necessary to combat fraud and hold down costs.

Regulators say a policy cannot be canceled for an unintended discrepancy between the policyholder's application and medical records.

Consumer advocates said they feared that unless regulators got tough on insurers, the practice would continue and the opportunity for meaningful reform could be lost.

"Regulators have to come in with a big stick, because otherwise Blue Cross and the other HMOs are going to buy off the individuals," said Jamie Court, president of the Foundation for Taxpayer and Consumer Rights, based in Santa Monica. "This has to be about more than money. It's got to be about forcing the companies to uphold the law, and that's the job of the regulators."

Amy Dobberteen, assistant deputy director of the Department of Managed Health Care, said the agency was taking the complaints seriously.

"Our investigations have begun on all major players on a systemic level and on a case-by-case basis," she said. "There's a lot to look into. We've certainly been looking into it diligently, and I don't think we've been moving slowly on this. We're acting."

California Insurance Commissioner John Garamendi pledged last spring to investigate Blue Cross' cancellation practices but hasn't reported any findings. A spokesman said Garamendi had heightened scrutiny of Blue Cross.

"We are continuing our probe into retroactive rescissions," said spokesman Norman Williams. "We recently refocused our personnel to look more closely into this issue."

Shernoff, the plaintiffs' attorney, said he would continue to press Blue Cross for substantial changes, such as reviewing an applicant's medical records before issuing coverage and canceling only when the insurer finds evidence that a policyholder intended to defraud the company.

He gave Blue Cross credit for discussing reforms. The company outlined operational changes last month designed to ensure that policies were not revoked in error. It is in discussions with lawyers and regulators on whether those steps adequately address the concerns raised in the suits.

"All the other insurance carriers are in denial," Shernoff said. "Blue Cross at least is not in denial anymore. They are in rehab now."