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Blue Cross Moves to Quell Furor

The health insurer, accused of dumping sick policyholders, says it will alter procedures.

Blue Cross of California said Tuesday that it would change some of its procedures for canceling individual health insurance policies, after allegations that it illegally dumped sick policyholders to avoid expensive claims.

The state's largest health insurer said it would make the changes — including creating an ombudsman and revising its appeal process — but maintained that it had done nothing wrong.

"The vast majority of rescissions to date are unquestionably proper under any criteria," said Blue Cross Chief Executive Dave Helwig. "But we are taking these major steps to minimize the possibility of errors."

Regulators who have launched investigations into the company's practices said they were eager to review the company's changes.

Consumer advocates and legal experts were skeptical that the company's plans would improve policyholder protections.

"I'm underwhelmed," said Bryan Liang, executive director of the Health Law Institute at California Western School of Law in San Diego. "The fundamental issue still is that they are not addressing these policies according to California law. Once they issue the policy, unless there is actual fraud, they cannot rescind. So despite whatever window dressing they put in place, they are still violating the law."

The moves come in the wake of several lawsuits filed by consumers against Blue Cross and its rival Blue Shield of California. The consumers bought individual policies that were later canceled because of what they say were innocent mistakes — or errors on the company's part.

The moves also come after the state's top HMO regulator said she was prepared to take action against Blue Cross — possibly as early as today or Thursday — after an investigation found that the company had violated a state law prohibiting health plans from canceling coverage unless they showed that policyholders willfully lied on their applications.

Blue Cross has 1 million California members on individual policies — almost half the market. Insurers can decline individual coverage or charge higher premiums based on a person's medical condition and history, unlike with most workplace-sponsored group plans, which are open to all qualifying employees regardless of history.

The company reiterated Tuesday that it needed the ability to revoke policies to guard against consumers lying about their health to obtain coverage. But the issue of fraud was noticeably absent from the changes Blue Cross announced.

"We know the issue of willfulness or intention is important, but we can't discuss it today," said Deborah

Lachman, a senior vice president in charge of individual policies. "That's something we're discussing with regulators currently."

The most visible change could be an application form that the company is developing with regulators and consumer lawyers. Lachman said the multi-page forms that require applicants to recall as much as 10 years of medical history will be simplified and cover, in most cases, no more than five years.

None of the changes would drive up premiums, Lachman said. Previously, however, the company has said that if every cancellation had to be backed up by a fraud investigation, the cost of the undertaking would force premiums higher.

William Shernoff, a Claremont lawyer representing several policyholders suing Blue Cross, said he was encouraged that the company was responding to the criticism and impressed with its effort.

"The major breakthrough is when you get a large corporation like this that says they are going to change their ways," he said. "But we'll see if these changes are going to be significant and real. The devil's in the details."

Jerry Flanagan, a patient advocate with the Foundation for Taxpayer and Consumer Rights, said the announced changes looked like an attempt by Blue Cross to avoid regulatory or legislative intervention and patch up its reputation.

"Blue Cross is in a world of hurt, and they are attempting to wiggle their way out of hot water by putting in some weak rules they can live with," he said. "They are making concessions in an attempt to wiggle out of more comprehensive reform."

Among other things, Flanagan said, it was hard to believe that a Blue Cross employee could act as an effective ombudsman for consumers.

Cindy Ehnes, the state's top regulator of health maintenance organizations as director of the California Department of Managed Health Care, said late Tuesday that her agency had not yet been able to fully analyze the effect of any changes at Blue Cross on its investigation.

"The DMHC has maintained all along that the law clearly protects consumers from inadvertent omissions or confusing applications," she said. "Consumers must be confident that their health insurance will be available to them and not be afraid that they could be canceled after making a claim. Protecting access to healthcare is our main concern, and it is clear that consumers have been harmed by the practices of some insurers."

State Insurance Commissioner John Garamendi, who also oversees some of the company's business, said his department "will very carefully look at these new policies to make certain that they adequately protect consumers and remedy any issues that have arisen in the settlement, or that we otherwise may identify."