

The Indianapolis Star
April 17, 2006
Danial Lee

HIGH-FLIGHT ATTORNEY TAKES ON WELLPOINT

10 lawsuits accuse Indy-based insurer of illegally dropping clients with costly care

William Shernoff built his lucrative career with headline-grabbing lawsuits against insurance companies.

He won a \$4.5 million punitive-damage jury award against Colonial Penn Franklin Insurance Co. for declining to pay an elderly man's \$48 medical bill.

He landed \$76 million for MGM Grand Hotel in a dispute over its insurance policy.

He represented the families of Holocaust victims whose claims were denied by European insurers. And his law partner won a \$120.5 million jury verdict against health insurer Aetna.

Now Shernoff is going after Indianapolis-based WellPoint Inc., the nation's biggest health benefits company. The veteran California lawyer last month filed 10 lawsuits against WellPoint's Blue Cross of California subsidiary, alleging that in recent years it systematically and illegally dumped policyholders who had costly medical care.

WellPoint -- which denies the allegations and promises a vigorous legal defense -- could be in for a fight. Shernoff is known not only for winning lots of money for his clients, his cases also have led to industry reforms.

Legal and insurance experts say a judgment against WellPoint could cost millions of dollars, spark reform efforts from state regulators and mar the reputation of the biggest company based in Indianapolis.

They call Shernoff, 68, a pioneer in suing insurance companies over denied payments to policyholders, a legal arena known as "bad faith" claims.

"He's the grand old guy of this business," said Eugene Anderson, a New York lawyer who also specializes in suing insurance companies. "It's just incredible."

In the world of trial lawyers, Shernoff is a gunslinger.

The New York Times in 1985 published a 1,300-word profile of him under the headline, "He makes insurers pay up."

"He's been a very effective lawyer in really changing insurance industry practices," said Tom Baker, a law professor and director of the Insurance Law Center at the University of Connecticut.

Among the biggest risks for WellPoint is a blow to the company's reputation, said Gary Claxton, vice president of the Kaiser Family Foundation. "These markets are competitive, and if you become seen as an insurer that won't pay claims, then you won't have policyholders," he said.

WellPoint said it has done nothing wrong.

"We are in full compliance with the legal obligations that we have to our members," said Edward West, senior

vice president of corporate communications for WellPoint. "We have not done what trial lawyer Shernoff alleges."

So far, both sides seem locked in a public relations war, with Shernoff portraying WellPoint as a profit-obsessed corporate giant with outrageously paid executives, and WellPoint insisting he is a trial lawyer out to grab big bucks by working his case in the court of public opinion. Shernoff's fee is 40 percent of any damages awarded.

The suits claim that Blue Cross used a "retroaction review department" to comb through already approved health insurance applications, looking for any potential misstatements or omissions so that it could cancel policies and avoid paying expensive medical claims.

At the heart of the dispute is an application form that people such as Yenny Hsu and Melanie Villa fill out when they apply for individual insurance.

In one of the lawsuits, Hsu, of Los Angeles, said that her policy was rescinded in November after she was diagnosed with breast cancer and had a mastectomy of her left breast, underwent chemotherapy and required more treatment.

Blue Cross canceled the policy because Hsu had failed to disclose on her original application that she had been exposed to hepatitis B, according to the suit filed by Shernoff. Hsu claimed she had been exposed as a child and was unaware of any problems from the exposure.

In another suit, Villa, also of Los Angeles, said she had an ovarian cyst removed, followed by a hysterectomy, before her policy was canceled in January because she had not disclosed "material medical history" on her application, according to the suit.

Villa said she thought she had provided the needed information for the application, including the name and phone number of her doctor. But she said Blue Cross pointed out that she had not disclosed that she had been treated for severe, migrainelike headaches in 2000.

That section on the application covering headaches, she said, appeared with conditions including seizures and epilepsy. "I had checked 'no' on that box," Villa said in an interview. "I didn't associate myself with seizures or stroke or epilepsy."

When the discrepancies were found, she said, Blue Cross did not contact her for more information but simply canceled the policy without telling her. She said she learned that her coverage had been dropped from a secretary at her doctor's office.

"I feel horribly, horribly violated and taken advantage of," Villa said.

Villa, a divorced mother of three, said she now has no medical insurance -- a constant source of stress.

"There's still a healing process with major surgery. Things can happen," she said. "There isn't a day that goes by without experiencing worry that, God forbid, if something happens to me, how am I going to take care of myself."

WellPoint's West said the company cannot comment on the specifics of the cases. But, he said, "We do not have a department within WellPoint that acts the way he described in his lawsuits."

The lawsuits also allege that Blue Cross' application is "designed to trap innocent persons" into misstatements and omissions by being overly broad and confusing. Shernoff points to sections on the

application that ask for disclosure of conditions such as "diarrhea," under a list of digestive problems, and "sprain/strain," under musculoskeletal problems.

Shernoff already seems to be looking beyond the 10 suits filed March 27 in California. "I'm sure that WellPoint doesn't only do this in California," he said, adding that several dozen other former Blue Cross policyholders recently contacted his office to report that they had been victimized.

The California Department of Insurance has said it is looking into the allegations raised in the 10 suits. The Kaiser Foundation's Claxton said it might be difficult to turn these sorts of complaints into a class-action suit because the members' circumstances are different. But he said the legal action, if it's successful, could prompt state regulators to crack down on the company's underwriting practices.

All of the plaintiffs had purchased individual policies. Those sorts of policies, unlike standard employee-sponsored health benefits, require a review of the applicant's medical history by the insurer. About 5.6 million of WellPoint's 33.9 million members nationwide are covered under individual or small-group policies.

Shernoff said he decided to group the 10 lawsuits after research for a previous case revealed that Blue Cross had a specific system set up for reviewing applications and medical histories after claims are submitted for members' care.

"That led me to the conclusion that this isn't an isolated thing here or there," he said. "This is a well-thought-out, systematic policy to review claims for the purpose of where they can rescind the policy."

WellPoint's West said his company -- like all health benefits companies -- reviews claims for accuracy and to prevent fraud, but he added that a very small number of policies are canceled. "Any assertion that we rescind coverage to avoid paying claims is just plain wrong," he said. A formal appeals process is available to any member whose policy is canceled, he said. And, he said, the company's process for reviewing claims helps hold down health-care costs for all members.

Others in the insurance industry say that some reviews of the claims process are needed.

Susan Pisano, spokeswoman for the trade group America's Health Insurance Plans, which advocates on behalf of health insurers, would not comment directly on the allegations against WellPoint. But she said health insurers have good reasons to conduct some reviews of the claims process.

"Claims are typically reviewed for accuracy, promptness of payment and fraud, which is in consumers' best interest because of the degree to which fraud contributes to health-care costs," Pisano said.

Baker, the Connecticut law professor, sees a tough fight ahead for Shernoff.

"He's going to have an uphill battle to prove that it's a business practice and that the business practice is wrongful," Baker said. "But he's used to uphill battles, for sure."