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Lawsuits Persuade Garamendi to Probe Blue Cross' Practices

California regulators said Wednesday that they would investigate accusations by 10 patients that Blue Cross has a system to retroactively cancel health coverage for members after they need expensive medical care.

State Insurance Commissioner John Garamendi called the allegations, made in a series of lawsuits, disturbing.

He said the claims were reminiscent of those that led him to impose an \$8-million fine last year on disability insurer UnumProvident Corp., which was accused of improperly denying benefits to thousands of Californians.

"If we see a pattern with Blue Cross Life & Health, they are in deep trouble," said Garamendi, whose office has been investigating whether the company reaps excessive profit.

Also Wednesday, the state Department of Managed Health Care, which oversees a related company called Blue Cross of California, said it would launch its own investigation into the allegations.

The department also is preparing to conduct a broad audit of Blue Cross' claims handling and the scope and frequency of policy rescissions, said Amy Dobberteen, the department's enforcement chief.

A key question in the audit, Dobberteen said, will be "What's the red flag for them to do a focused investigation into an enrollee's medical history?"

State law prohibits retroactive cancellations without evidence that a member lied or failed to disclose preexisting conditions.

Indianapolis-based WellPoint Inc., which owns both California Blue Cross units and many others around the country, said it welcomed the opportunity to review with regulators the way it vets applicants for coverage and handles medical claims.

The company denied any wrongdoing and said it would fully cooperate with investigators.

"We are in full compliance with the legal obligations to our members," WellPoint spokesman Robert Alaniz said.

Depending on the outcome, the investigations could lead to fines and other penalties. WellPoint, the nation's largest health insurer, also could be forced to make good on disputed claims and to reinstate the former members' coverage.

The probes stem from bad-faith allegations lodged in 10 lawsuits filed Monday in Los Angeles, Orange, San Bernardino and Riverside counties.

The plaintiffs, represented by Claremont attorney William M. Shernoff, are former Blue Cross members who

allege the company reneged on its obligation to pay their medical expenses and dropped them from their plans after authorizing treatment for serious conditions, including breast cancer and heart disease.

The suits accuse Blue Cross of operating a "retroactive review department" that, in an effort to boost profit, systematically cancels policies that result in large claims.

The patients say they were suddenly left with hospital bills, some exceeding \$100,000. Some say they've been unable to afford needed follow-up care because their coverage was dropped.

They allege that Blue Cross scours years of medical records after expensive claims have been submitted, looking for innocent misstatements and omissions to use as pretext to rescind coverage and escape expensive bills.

The suits also accuse Blue Cross of using a vague, confusing and ambiguous medical history questionnaire in an effort to trick applicants into making mistakes that the company can use later to dump them.

The spate of accusations should persuade regulators to impose a simple, clear and uniform medical history questionnaire on all health insurers, said Jamie Court of the Santa Monica-based Foundation for Taxpayer and Consumer Rights.

He also said that if Blue Cross was shown to have a department devoted to denying claims and canceling coverage, regulators should disband it.

"It's scandalous that the nation's largest and most profitable health insurer would have a secret special operations unit that seeks to dump policyholders that cost too much money," Court said in letters to regulators.

WellPoint's Alaniz said the company did employ a group of people who reviewed claims. But, he said, the group was not officially called the "retroactive review department," nor does it do anything wrong.

Alaniz said Blue Cross owed it to honest members to guard against fraud in applications for coverage and in claims.

"Our policies and procedures with respect to claims reviews are designed to ensure that insurance premiums remain affordable for our members," Alaniz said. "It's important that we issue policies based on accurate information filed by the member."

Alaniz declined to say how frequently Blue Cross rescinded policies.

The company processed more than 11 million claims and paid \$1.3 billion to cover the care of members last year.