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State fines Blue Cross $200,000

State regulators Thursday began cracking down on health plans accused of illegally dropping policyholders to avoid paying claims.

In its first move, the Department of Managed Health Care levied a $200,000 fine on Blue Cross of California for wrongfully canceling coverage of a Los Angeles-area woman after she filed a claim for a routine doctor's visit.

The penalty stems from a wider state probe into the illegal practice of insurers rescinding consumers' policies and then refusing to pay the medical bills. It is unclear how many of California's more than 500,000 consumers with individual health plans are affected, but one consumer group predicts the number could be in the thousands.

The state, which has received about 200 complaints, is investigating practices at Blue Cross, Kaiser Permanente and Blue Shield of California.

"It's been a long-standing practice. It's quite widespread in the individual (insurance) market," said Cindy Ehnes, director of the Department of Managed Health Care. "Insurers have traditionally been accused of cherry picking that market. This is an example."

Blue Cross spokesman Robert Alaniz said the fine was based on an isolated case and that the company was addressing the issue with a new initiative. On Tuesday, the state's largest health insurer unveiled a series of changes to reduce mistakes, including establishing an ombudsman and introducing a new application form.

"We are disappointed that the (state) chose to proceed with this action," Alaniz said. "We realize we can always improve. We're not perfect."

A consumers group said the penalty was too small to stop the practice.

"One $200,000 fine is not a deterrent. It's a very profitable business practice," said Jerry Flanagan of the Foundation for Taxpayer and Consumer Rights. "The number (of consumers affected) could easily get into the thousands."

A Blue Shield official said Thursday his company is following the law, which allows insurers to cancel policies if they can prove patients knowingly lied about past medical conditions. Kaiser officials said they are reviewing the issue.

Critics say consumers have purchased policies that were later dropped because of innocent errors or mistakes made by the HMOs. They contend health plans often launched their reviews after customers become sick and filed claims.

In the Blue Cross case, regulators said a Los Angeles woman lost her coverage after a routine doctor's visit in early 2005. The health plan canceled her policy because they learned she omitted on her application form

information about a corrective surgery performed two decades earlier.

The company, however, had asked for only a 10-year medical history. Moreover, regulators said the company couldn't prove she intended to misrepresent her medical background.

Critics say Blue Cross and other health plans have special units searching for reasons to rescind policies retroactively.

"It has been going on for years. People are appalled by it," said William Shernoff, a Southern California attorney representing about 80 consumers who are suing major health plans, including Blue Cross, Blue Shield and Health Net.

Shernoff said the changes proposed by Blue Cross are a start. The key, he said, is whether the revisions are "significant and cure the problem."

In additional to individuals, a group of Southern California hospitals has filed suit against Blue Cross to recover payments for services to patients dropped by the insurer.

"Once Blue Cross has authorized service they have to pay," said Daron Tooch, a Los Angeles attorney representing the hospitals.

He said hospitals end up trying to collect from patients who can't afford to pay hefty bills -- some topping $100,000.

"It puts the hospitals and the patients in a very bad situation," Tooch said.