

Health Insurance Company Abuses

How the Relentless Drive
For Profit Endangers Americans

June 2009

HEALTH CARE
FOR AMERICA **NOW!**

Health Insurance Company Abuses

Table of Contents

Introduction	2
Abuses	
1. Insurers Leave Patients with High Out-of-Pocket Costs	4
2. Insurers Deny Coverage for Medically Necessary Care	7
3. Insurers Discriminate Against Women	12
4. Insurers Wrongly Drop People’s Coverage.....	14
5. Insurers Scam People Through Marketing Abuses	17
6. Insurers Defraud Taxpayers.....	19
7. Insurers Reward Employees for Denying Coverage	22
8. Insurers Export Dollars Over State Lines to Help Affiliated Companies	23
9. Insurers Reward CEOs for Bad Practices.....	24
10. Insurers Deny Emergency Care.....	25
11. Insurers Overcharge Small Businesses.....	27
12. Insurers Collude With Some Providers to Drive Up Prices.....	28
13. Insurers Prevent Doctors from Delivering Care They Feel Is Best for Their Patients.....	29
14. Insurers Delay Reimbursement to Patients and Providers.....	30
15. Insurers Deny Rural Americans Good Coverage.....	34
16. Insurers Oppose Steps to Create Health Security.....	36
Index of States	39

Introduction

Private Insurers Pledge to Behave Under Tighter U.S. Rules, But Companies Have Outmaneuvered Regulators for Decades

The health insurance industry wants Congress to drop the idea of creating a public health insurance plan, even though polls consistently show the American public wants the option to join one. Insurers say meaningful health reform can be achieved instead with additional federal regulation of their industry. As the heart-wrenching personal stories in this document demonstrate, the insurance industry has a long record of dishonesty and of ignoring laws and regulations in its remorseless pursuit of profits. Simply enacting a few new regulations—and shifting responsibility for enforcing them from the states to federal agencies that lack the funding to do the job well—is not a way to transform a notoriously untrustworthy industry into an honest one.

Health Care for America Now (HCAN), a national coalition of more than 1,000 groups, believes Congress should extend affordable, quality coverage to everyone in a reformed system that includes a voluntary public health insurance plan to compete with private insurers. A public insurance plan will hold down underlying health costs across the nation and keep private plans honest by competing with them. In the existing environment, the insurers mainly compete to avoid covering the sickest 10 percent of the population that accounts for 70 percent of health care spending.

In this compilation of published accounts and personal stories submitted to HCAN by patients and families, the insurers cited most often are the for-profit companies that have come to dominate the industry since derailing President Clinton's health reform plan in 1993. Last year the total revenue of the seven largest companies totaled more than \$250 billion. As this report shows, nonprofit insurance companies have different financial structures from publicly traded insurers, but they are no less determined to deny care to policyholders to bolster corporate income. They control about half of the private health insurance market.

Insurance company executives know they can ration care with impunity because independent analysts cannot review their secret practices. And state insurance regulators have inadequate staffs and budgets, so violations often go unnoticed by them. The challenge for regulators is compounded by state laws that do not require insurers to disclose enough information about business practices so the public and the regulators can gain a clear picture of how insurers really operate. Consequently, insurer practices that systematically deny people needed care are rarely exposed except in anecdotal media accounts.

Even when illegal activity is caught, the fines that insurers pay to settle allegations represent a tiny fraction of their annual revenues and earnings. For the cartel of giant insurers that has emerged from the rapid and continuing consolidation in the industry, fines that run into the millions of dollars are nothing more than footnotes on the companies' earnings reports. Insurers have come to accept the fines for even the most egregious violations as a manageable cost of doing business and have no qualms about risking being caught repeating their misconduct. The cost to millions of people enrolled in health plans, however, is often very high.

The beneficiaries of the illegal and fraudulent activity described in this report are the Wall Street investors who own big, for-profit insurance companies. Canceling policies and denying legitimate

medical claims are among the myriad ways insurers avoid spending premium dollars on care, leaving more money available to reward shareholders and company executives. This is referred to on Wall Street as “enhancing shareholder value.”

Another way to boost earnings is to dramatically increase premiums when policies come up for renewal, even though the increases are often based on little more than greed. The experience of the Harris County Medical Society in Texas provides an astonishing but all-too-common example. In 2006, the medical society’s health plan was presented with a “take it or leave it” rate increase of 22 percent for a so-called “consumer-driven” health plan administered by Blue Cross and Blue Shield of Texas. Yet the year before, Blue Cross had paid out only 9 percent of the medical society’s premium dollars for claims. The Society, composed of physicians who should be the savviest health care consumers, would never have been told what a bad deal it was getting if it weren’t for a new Texas law that requires health plans to disclose the share of premium revenue they spend on health care—but only when asked about it by customers.

Health care reform requires stronger regulation, but that isn’t enough. It must also ensure quality benefit packages, require disclosure of data that shows how insurers really operate, and provide genuine competition from a public health insurance plan that is more accountable to the American public than it is to Wall Street.

Until then, the American people can expect the insurance industry to remain intransigent, as it vividly demonstrated in Congress this week. Despite harsh comments from members of Congress and testimony from outraged customers, major health insurance companies said in a hearing they have no plans to change practices that deny care to sick people when they need it most. Here is how the Los Angeles Times reported the story on June 17, 2009¹:

“Executives of three of the nation’s largest health insurers told federal lawmakers in Washington on Tuesday that they would continue canceling medical coverage for some sick policyholders, despite withering criticism from Republican and Democratic members of Congress who decried the practice as unfair and abusive.

“The hearing on the controversial action known as rescission, which has left thousands of Americans burdened with costly medical bills despite paying insurance premiums, began a day after President Obama outlined his proposals for revamping the nation’s healthcare system.

“An investigation by the House Subcommittee on Oversight and Investigations showed that health insurers WellPoint Inc., UnitedHealth Group and Assurant Inc. canceled the coverage of more than 20,000 people, allowing the companies to avoid paying more than \$300 million in medical claims over a five-year period.

“It also found that policyholders with breast cancer, lymphoma and more than 1,000 other conditions were targeted for rescission and that employees were praised in performance reviews for terminating the policies of customers with expensive illnesses.”

¹ <http://www.latimes.com/business/la-fi-rescind17-2009jun17,0,5870586.story>

1. Insurers Leave Patients with High Out-of-Pocket Costs

Health Plans pay unreasonably low rates for out-of-network doctors' services, leaving subscribers with high out-of-pocket costs. For example:

- If Aetna enrollees wondered why their bills from out-of-network doctors were so high, here's the answer: Aetna was underpaying providers and leaving patients to fork over the rest, according to **New Jersey** regulators, who in 2007 fined Aetna almost \$9.5 million.

- "DOBI levies nearly \$9.5 million in penalties against Aetna Health," New Jersey State Department of Banking and Insurance, July 2007 (www.state.nj.us/dobi/pressreleases/pr070725.htm)

- **New York** Attorney General Andrew Cuomo investigated Aetna, United Healthcare, CIGNA, and other health insurers for what he called "an industry-wide scheme perpetrated by some of the nation's largest health insurers to deceive and defraud consumers."

- "Cuomo Announces Industry-Wide Investigation Into Health Insurers' Fraudulent Reimbursement Scheme," State of New York Office of the Attorney General, February 2008 (www.oag.state.ny.us/media_center/2008/feb/feb13a_08.html)

- Janet Stephens, an Anaheim nurse, told regulators about her struggles with **California** Blue Cross (now Anthem Blue Cross) after it became part of WellPoint Inc. in a huge merger. When she first subscribed, her premiums were \$252 a month. Now her premiums are \$589 a month for a plan with a \$1,500 deductible and a separate \$500

prescription drug deductible. Stephens took out home equity loans and sold household items to help pay off \$8,000 in bills at the pharmacy. Her co-pays have increased ten-fold. "I'm facing the dire medical and financial consequences as (Blue Cross) seeks to pay for its lucrative merger," she told the California Department of Managed Health Care.

- "Cross-Examining Blue Cross," Health Access Weblog, Health Access California, August 10, 2007 (www.health-access.org/2007/08/regulators-cross-examine-blue-cross.htm)

- The first study of its kind found that families typically pay much more out of pocket for maternity care under the new high-deductible health insurance plans paired with health savings accounts. The study found that those enrolled in a traditional health plan for federal employees (with a \$500 annual deductible and \$20 co-payments for office visits) would likely pay \$1,455 out of pocket for care during an uncomplicated pregnancy and delivery.

Higher Out-of-Pocket Costs

Curt B.* of Pocono Summit, Pa., shared his experience with higher than expected out-of-pocket costs for out-of-network care:

"I worked for 33 years in the state of New York before retirement. During my active employment years, I was fortunate to have family-coverage, employer-provided health insurance, paid for to a large extent by the employer. I was able to carry my health insurance plan into retirement, with me paying about 14 percent of the annual \$15,000 family coverage premium.

"After retirement, I moved to Pennsylvania. When I need the services of a doctor here, I find most of the doctors to be what my insurance company calls 'out-of-network' physicians. What my insurance company allows of their health care delivery charge is usually less than 50 percent of what they charge. The insurance company then gives me a check for 80 percent of that allowable amount and the rest of the charge must be paid by me. Recently, the allowable amount of a \$700 charge for a prostate cancer procedure was a mere \$280, leaving me to pay \$476 to the doctor."

** Most stories in the shaded boxes were sent to Health Care for America Now by patients and families. Some individuals are only partially identified at their request.*

That compared to \$3,000 for families in a high-deductible plan for federal employees and \$7,000 for a high-deductible plan offered through small businesses. The gap generally widens with pregnancies that require more expensive care or longer hospital stays. For example, a woman who delivered by Caesarean section in an otherwise uncomplicated pregnancy would likely pay \$2,244 in out-of-pocket costs under the traditional plan, \$3,545 under the federal high-deductible plan and \$7,688 under the small-business plan. In addition, routine prenatal care often is not covered as preventive care in high-deductible plans, the study found.

- “High-Deductible Plans Cost More For Maternity Care,” Christopher Lee, *The Washington Post*, June 13, 2007 (www.washingtonpost.com/wp-dyn/content/article/2007/06/12/AR2007061201817_pf.html)
- Tracy Cooper couldn't believe her health insurer tried to stick her with a \$16,000 hospital bill. The company said her insurance didn't cover that hospital. Cooper, however, didn't have any choice—she was unconscious when paramedics rushed the Shawnee, **Kansas**, woman to the hospital.
 - Complaints burn customers trust,” Mike Casey, *Kansas City Star*, December 10, 2006 (http://nl.newsbank.com/nl-search/we/Archives?p_product=KC&p_theme=kc&p_action=search&p_maxdocs=200&p_topdoc=1&p_text_direct-0=115F0485CC7A61B8&p_field_direct-0=document_id&p_perpage=10&p_sort=YMD_date:D&s_trackval=GooglePM)
- A Texas company that sells low-cost health insurance to small businesses and students was sued by **Massachusetts** Attorney General Thomas F. Reilly's office, which alleges it used deceptive marketing practices and improperly denied patient claims. The company, MEGA Life and Health Insurance Co., and a related firm, Mid-West Life Insurance Co. of Tennessee, are owned by HealthMarkets, which sells limited-coverage insurance plans nationwide. At least 30,000 Massachusetts residents have MEGA Life and Mid-West insurance plans, according to state figures. Such limited-coverage plans have been criticized by some health care advocates as inadequate. They feature low premiums and high out-of-pocket expenses.
 - “AG sues low-cost health insurer on practices,” Christopher Rowland, *Boston Globe*, October 24, 2006 (www.accessmylibrary.com/coms2/summary_0286-23070822_ITM)
- Georgia's largest health insurer drew a \$100,000 state fine for offering cheaper insurance options to some policyholders but not others. The state insurance commissioner said Blue Cross and Blue Shield of **Georgia**, a subsidiary of WellPoint Inc., must give 33,000 individual policyholders the same choices that others received, which could save consumers more than \$8 million. He also said his agency is investigating Blue Cross' increases in health insurance premiums for individuals. Blue Cross raised premiums for its 2005 individual health policies by an average of 36 percent, with some getting 100 percent increases, he said.
 - “Georgia fines Blue Cross and Blue Shield \$100,000 for price variances,” Andy Miller, *Atlanta Journal-Constitution*, December 9, 2005 (www.accessmylibrary.com/coms2/summary_0286-17862465_ITM)
- Consumer advocate Linda Sherry is an expert when it comes to reading fine print and getting through to customer service. But when her health insurance company denied many of the charges related to a detailed physical, Sherry felt like the poster child for aggrieved consumers. Under her indemnity plan, Sherry can get care from any doctor or hospital and is reimbursed for a percentage of the charge. Patients often assume the insurer will pay a set share – typically 80 percent – of the actual charge if they are in an indemnity plan or go out

of network with a managed-care plan. The reality is that insurers pay only a percent of what they designate to be a "usual, customary and reasonable" charge. If that amount is lower than the actual charge, the provider takes a loss or the patient is stuck paying the difference. One of Sherry's tests cost \$442, but her insurance company said it would pay only 80 percent of \$121, which was the amount it considered usual, customary and reasonable. According to Lawrence Gelb, CEO of CareCounsel, a firm hired by companies to help employees resolve insurance claims, there is no government regulation that sets standards for insurers to determine what is usual and customary. And insurance companies don't disclose their rates before a procedure is billed. "This is the great black box of the healthcare industry," said Gelb.

- "The fuzzy math of health insurance: When an insurer's idea of usual, reasonable and customary comes up short, you're stuck paying," Sarah Max, CNN/Money, August 30, 2005 (http://money.cnn.com/2005/05/26/pf/insurance/usual_and_customary/)
- When Darlene Henderson was diagnosed with breast cancer in 2001, the illness devastated her body and soul. Soon afterward, the Henderson's husband David was felled by an abdominal aortic aneurism the size of a baseball and rushed to surgery. As the self-employed couple from Penn Valley, **California**, struggled to recover from three major surgeries each, they took comfort in the knowledge that they bought \$1 million worth of catastrophic medical insurance through a business association. Or so they thought—until a blizzard of medical bills topping \$210,000 buried them. The Hendersons soon learned their insurance would cover less than 20 percent of the bills, plunging them into a financial crisis.
 - "Penn Valley, Calif., couple fights to educate consumers on medical insurance," Andrew McIntosh, *Sacramento Bee*, August 29, 2005 (www.accessmylibrary.com/coms2/summary_0286-17817900_ITM)
- A company that operates two large health insurance plans in upstate **New York** was fined \$500,000 for violations that included deleting thousands of valid claims from its computer system and systematically underpaying claims for outpatient psychiatric services. The fine was imposed in 2000 by the State Insurance Department on HealthNow New York Inc., a nonprofit company based in Buffalo that operated Blue Cross and Blue Shield of Western New York and Blue Shield of Northeastern New York. Together, the plans had about 750,000 subscribers.
 - "New York State Fines Insurer \$500,000," Joseph P. Fried, *The New York Times*, August 2, 2000 (www.nytimes.com/2000/08/02/nyregion/metro-business-new-york-state-fines-insurer-500000.html)

2. Insurers Deny Coverage for Medically Necessary Care

Insurance companies use many reasons to avoid paying out claims in order to bolster their profits. For example:

- Assurant Health, ordered by the **Connecticut** Insurance Department in 2007 to pay restitution to patients whose claims were improperly quashed by the company's subsidiaries, supposedly because of preexisting conditions. In the words of the state attorney general: "Assurant calculatingly denies coverage for catastrophic illnesses... Assurant promised benefits, but abandons them when they face cancer and other devastating diseases."
 - "Insurance Commissioner Enters Into Consent Order With The Assurant Companies," Connecticut Insurance Department, March 2007 (www.ct.gov/cid/cwp/view.asp?A=1269&Q=335734)
- From the Connecticut attorney general's press release: "In the case of *Mitchell v. Fortis Insurance Company* [an Assurant subsidiary], a **South Carolina** court found that Fortis pre-programmed its computer to recognize billing codes for expensive health conditions, triggering an automatic fraud investigation. The court awarded \$15 million to the plaintiff, who was improperly denied coverage by Fortis for his AIDS treatment."
 - "Attorney General Says Court Ruling Confirms Suspicions Of Abusive, Pervasive Insurance Coverage Denials," Connecticut Attorney General's Office, March 2007 (www.ct.gov/AG/cwp/view.asp?A=2788&Q=333838)
- It would be hard for PacifiCare, a subsidiary of UnitedHealth Group Inc., to argue that 133,000 mishandled claims were just a mistake. For the violations, **California** regulators hit the company with a record \$3.5 million fine – a penalty that may ultimately reach \$1.3 billion when an investigation is completed. The laundry list of alleged health insurance misdeeds: wrongfully denying covered claims, failing to properly manage provider networks, making incorrect payments, making multiple requests for previously provided documentation, and so on. Here's some of the damage, courtesy of the *Sacramento Bee*: A surgeon was blocked from scheduling surgeries for six months; more than 200 patients of a pediatrician were told he wasn't in the insurer's network anymore; a father fought for 11 months to get claims paid for his autistic child while his wife put off heart-stress tests.
 - "PacifiCare fined record \$3.5 million," by Gilbert Chan, *Sacramento Bee*, January 30, 2008 (www.sacbee.com/103/story/672192.html)
- An **Oregon** woman who complained to the state after PacifiCare Life Assurance Company, a subsidiary of UnitedHealth Group Inc., denied six of her seven medical claims, helped launch a state investigation that overturned nearly 5,000 other claim denials. Regulators fined PacifiCare \$46,000 for failing to conduct reasonable investigations before denying claims, making policyholders with pre-existing conditions wait more than six months for coverage of

Excuses, Denials

Carlene K. of McCook, Neb., related the different excuses her insurance company used to deny payment for care she needed, including that her problem was "pre-existing":

"I had a date set for back surgery, but my insurance company denied authorization, claiming it was experimental. They said that even though both Medicare and Medicaid pay for this procedure. So now I sit here with growing back problems and will in all probability end up in a wheelchair due to nerve damage.

"Also, my insurance company denied payment for a sinus surgery I had. It claimed the surgery was needed due to a pre-existing condition and thus not covered. I am now being sued by the hospital for the bill that I do not have the money to pay."

those conditions, and for failing to act promptly on a claim. As a result of the investigation, PacifiCare reviewed more than 10,000 denied claims and determined it should have paid 4,928 of them. It also discovered that it erred in denying some claims involving pre-existing conditions.

- "Insurer fined for improperly denying health claims," Press Release, Insurance Division, Department of Consumer & Business Services of Oregon, December 30, 2008 (www.oregon.gov/DCBS/docs/news_releases/2008/nr_ins_12_30_08.pdf)
- WellPoint Inc. denied a woman coverage of special prosthetic legs she needed. The Virginia Bureau of Insurance reviewed her case after receiving a call from "Good Morning America." Within a few weeks, the state overruled WellPoint's **Virginia** subsidiary, Anthem Blue Cross and Blue Shield, and ordered it to pay for her new legs.
 - "Amputee Fights for Coverage of Prosthetics," Chris Cuomo & Gerry Waschal, ABC News, January 14, 2009 (<http://abcnews.go.com/GMA/GetsAnswers/story?id=6640663&page=1>)
- WellPoint Inc. was barred from enrolling new members in its Medicare drug and medical plans **nationwide** after it admitted that computer errors were denying prescription drugs to the elderly and causing some to be overcharged. The government said the actions endangered members' lives.
 - "WellPoint Cut Elderly off from Medicines, U.S. Says (Update 3)," Avram Goldstein, *Bloomberg News*, January 12, 2009 (www.bloomberg.com/apps/news?pid=newsarchive&sid=aMPsLxs27wc8)
- Horizon Blue Cross and Blue Shield of **New Jersey** agreed to cover claims stemming from eating disorders, settling a class action lawsuit brought by parents of children suffering from anorexia. The decision will lead to 500 patients receiving \$1.2 million after previously denied claims are honored. Under the terms of the agreement, Horizon will not admit any liability but will provide "parity treatment to eating disorder claims in the future for all current members who are fully insured."
 - "Insurer agrees to \$1.2M settlement in anorexia lawsuit," Guy Sterling, *The Star-Ledger*, November 25, 2008 (www.nj.com/news/index.ssf/2008/11/insurer_agrees_to_12m_settleme.html)
- Judith Reimann's cancer spread through her liver, pancreas and small intestine. After other treatments failed, her physicians at **Indiana** University Hospital proposed an unusually aggressive form of treatment: a multiple transplant of a liver, pancreas, and small intestine from a deceased donor. The surgery was estimated to cost about \$1 million dollars. WellPoint Inc.'s Anthem subsidiary in Indiana denied coverage of the proposed transplant, labeling the procedure not medically necessary and arguing that there is insufficient evidence to expect it would benefit a patient whose cancer has spread beyond the liver.
 - Reimann v. Anthem Insurance Companies, Inc., 2008 U.S. Dist. LEXIS 88562 (S.D. Ind.), October 31, 2008 (www.sickprofits.org/back/Reimann.v.AnthemS.D.Ind.10.31.08.pdf)
- Eighteen-year-old Chanel Bunce of Seattle, **Washington**, died of a rare inflammatory disease after Regence BlueShield denied coverage of a medication prescribed by her rheumatologist. The insurer said the treatment was "experimental" and not covered by her plan. After three weeks of repeated denials, her major organs collapsed.
 - "Investigators: Doctors say insurers target costly drugs," Chris Ingalls, King 5 News, May 12, 2009 (www.king5.com/topstories/stories/NW_051209INV-insurance-doctors-KS.1beb2698.html)

- Because Crystal Engle’s mom died at 40 of colon cancer, her doctors in Roanoke, **Virginia**, said she needed a colonoscopy screening at least 10 years before she turns 40. She’s 31 now, so she had the colonoscopy but was surprised when she got two letters from WellPoint Inc.’s Anthem Blue Cross and Blue Shield subsidiary, saying she owed the providers \$700. After three months of dealing with the claim, Engle contacted a television station. The company said benefits fall into a gray area for preventive tests, and medical reviewers concluded her policy covers a colonoscopy only for people at least 40 years old. The day of the TV interview, the company paid the claim.
 - "Medical Bill Battle," Karen McKnew, WSLs 10, May 1, 2008 (www.wsls.com/sls/lifestyles/health_med_fit/article/avoiding_health_insurance_headaches/10225/)
- **California** health insurance regulators levied a \$3.5 million fine against PacifiCare, a subsidiary of UnitedHealth Group Inc. The state Department of Managed Health Care issued the fine after a joint investigation with the state Department of Insurance found PacifiCare from 2005 to 2007 had more than 130,000 claims processing violations. State regulators said that PacifiCare improperly denied 30 percent of claims reviewed during the investigation.
 - “California Regulators Issue \$3.5M Fine Against UnitedHealth Subsidiary for Alleged Claims Processing Violations,” Health Care Marketplace, Kaiser Daily Health Policy Report, January 30, 2008 (www.kaisernet.org/daily_reports/rep_index.cfm?DR_ID=50126)
- David Denney a **California** teenager diagnosed with glutaric acidemia Type 1, has severe brain damage and needs constant attention from a nurse due to his inability to move on his own and the danger of frequent seizures. At the age of 13, his family's insurer, Blue Cross of California, a subsidiary of WellPoint Inc. decided that David no longer needed that assistance and stopped paying for the nurse, contrary to the recommendations of David's physicians, forcing the family to rely on Medi-Cal and sue Blue Cross.
 - “Family rejects Blue Cross' claim,” Lisa Girion, *Los Angeles Times*, December 30, 2007 (<http://theenvelope.latimes.com/la-fi-deny30dec30,0,4379963.story?page=1>)
- The parents of a 17-year-old girl who battled leukemia say they will sue Cigna Corp. over her death. Cigna initially denied coverage for the teen's transplant, saying it was "experimental." But following a public protest on Dec. 20, 2007, at its offices in **California**, the health insurer reversed and agreed to cover the procedure. Several hours later, she died.
 - “Health Insurer to Be Charged With Teen's Murder: California Family Will Sue Medical Insurer for Delaying a Potentially Lifesaving Surgery,” ABC News, Dec. 21, 2007 (<http://abcnews.go.com/GMA/CancerPreventionAndTreatment/story?id=4038257&page=1>)
- Nearly every Blue Cross and Blue Shield plan in the **nation** settled allegations in the past several years that it conspired to misrepresent the use of edits to unilaterally "bundle," "downcode" or reject claims for medically necessary covered services; and that it improperly denied, delayed or reduced payments for medically necessary covered services. The settlements included \$131 million in compensation and requirements that the insurers use clinical guidelines and established definitions of medical necessity that they commission independent external review boards to resolve common billing disputes with physicians.
 - Blue Cross Blue Shield settlement information,” American Medical Association, June 2007 (www.ama-assn.org/ama/no-index/legislation-advocacy/18037.shtml)
- While UnitedHealth Group Inc, profits were soaring and its CEO was collecting more than a billion dollars in stock options, **Nebraska** doctors, hospitals and patients were experiencing

frustrating claim payment problems, according to Department of Insurance records. The agency levied the \$62,500 fine in 2004 and began an investigation of the company's claims-paying practice. The fine, one of the largest for a health insurance company in Nebraska, stemmed from three cases where the company did not pay claims for anesthesiology services for children's dental work until state regulators intervened. In one case a claim was reprocessed at least five times over eight months. Even after the company knew payment was required, problems continued, according to state documents. The agency audit in 2004 of both the health maintenance organization and preferred provider organization services indicated claims that were eligible were not being paid and claims were getting lost.

- "Regulators, hospitals, doctors say UnitedHealth Group had claims problems in Nebraska," Nancy Hicks, *Lincoln Journal Star*, May 14, 2006 (www.journalstar.com/articles/2006/05/14/business/doc4464f469a7ab0472395745.txt)
- The **Arizona** Department of Insurance ordered United Healthcare to pay \$364,750 in civil penalties for illegally denying more than 63,000 physician claims without receiving all the information necessary to make the decisions and for failing to follow state laws for promptly notifying doctors and patients about decisions and appeals.
 - "United Healthcare fined \$364,750," Scott Simonson, *Arizona Daily Star*, March 11, 2006 (www.azstarnet.com/allheadlines/119565)
- **Connecticut** Attorney General Richard Blumenthal released a report finding that WellPoint Inc.'s Anthem Blue Cross and Blue Shield subsidiary and the company it hired to manage behavioral health claims for 600,000 enrollees, Psych Management Inc. (PMI), arbitrarily denied medically necessary mental health care for vulnerable patients. Blumenthal said PMI was motivated by greed when it embarked on a campaign to cut coverage and care needed by plan enrollees.
 - "Blumenthal Finds Anthem, Psych Management Denied/Limited Coverage to Vulnerable Patients," Press Release, Connecticut Attorney General's Office, February 14, 2002 (www.ct.gov/ag/cwp/view.asp?A=1777&Q=283724)
- **Connecticut** Attorney General Richard Blumenthal urged reforms to eliminate patient abuse and financial mismanagement by HMO carve outs—companies that subcontract with insurance companies to handle claims for a particular field of medicine, such as behavioral health.
 - "Blumenthal Testifies Before Legislative Committee on Reported Abuses by Managed Care Subcontractors," Press Release, Connecticut Attorney General's Office, February 14, 2002 (www.ct.gov/ag/cwp/view.asp?A=1777&Q=283726)
- The **Connecticut** Attorney General's Office helped a mother fight WellPoint Inc.'s Anthem Blue Cross and Blue Shield after the insurer refused to cover a prescribed formula necessary for her infant to survive a life-threatening condition.
 - "Anthem BC/BS to Pay for Special Formula for Skyler Austin, Attorney General Announces," Press Release, Connecticut Attorney General's Office, October 30, 2000 (www.ct.gov/ag/cwp/view.asp?A=1775&Q=283008)
- WellPoint's Empire Blue Cross and Blue Shield was fined \$1.1 million for violating **New York** state insurance law. The company denied physical therapy claims when services were performed by chiropractors without investigating whether they were licensed physical therapists and should have been paid. Empire also rejected some chemotherapy claims but paid for other patients seeking the same treatment; failed to reimburse subscribers for some

prescription drug and medical equipment claims; and failed to maintain accurate and complete files, resulting in delays to subscribers.

- o “Empire Blue Cross Is Fined \$1.1 Million, Setting Record,” AP, *The New York Times*, March 2, 1996 (www.nytimes.com/1996/03/02/nyregion/empire-blue-cross-is-fined-1.1-million-setting-record.html)

3. Insurers Discriminate Against Women

Insurance companies, in their zeal to avoid risk, discriminate against women because the insurers consider childbirth s risky and expensive. For example:

- “Please keep up the good work with the marketing reps of not trying to sign up pregnant women.” That thank you went out to company managers in a 2001 e-mail from Amerigroup Corp.’s **Illinois** director of medical management. Five years later, a federal jury awarded plaintiffs \$48 million in damages from the insurer and its parent company for discriminating against people with health conditions and pregnant women enrolled in the federal Medicaid program. That kind of discrimination is still allowed in many states.
 - “Nowhere to Turn: How the Individual Health Insurance Market Fails Women,” National Women’s Law Center, September 2008 (http://action.nwlc.org/site/PageNavigator/nowhere/return_Report)
- Data from insurance companies and online brokers for the individual insurance market shows that women pay much more than men of the same age for individual insurance policies providing identical coverage—if they can get coverage at all. For example, one insurer in **Missouri** charges 40-year-old women 140 percent more than men for similar coverage.
 - “Amerigroup Must Pay at Least \$144M After Jury Found HMO Systematically Avoided Enrolling Pregnant Women Kaiser Daily Health Policy Report,” Health Care Marketplace, Kaiser Daily Health Policy Report, November 01, 2006 (www.kaisernetwork.org/Daily_reports/rep_index.cfm?DR_ID=40792)
- The number of individual health insurance policies that do not cover maternity care has risen dramatically in recent years, prompting concern among consumers and a legislative effort to require **California** insurers to include the benefit.
 - “Few individual health policies cover maternity,” Victoria Colliver, San Francisco Chronicle, Tuesday, March 24, 2009 (www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2009/03/24/MN9416HD33.DTL)
- Women with individual health plans face higher costs and waiting periods. If you’re a woman dependent on an individual health insurance plan, you may find yourself spending a bundle to maintain maternity coverage.
 - “Paying the price for pregnancy,” Anya Martin, MarketWatch, *The Wall Street Journal*, March 11, 2009 (www.marketwatch.com/news/story/women-without-employer-health-plans/story.aspx?guid={974CA943-2223-4375-8A82-F1F991E9FB51}&dist=msr_1)
- The justification for charging women two or three times more than men for individual health-insurance policies demands a closer look, preferably by Congress, according to the Toledo

Rejected for Being Pregnant

Jeanette C. of Lexington, Ky., shares the story of her daughter’s inability to get health insurance because she is pregnant.

“My daughter was covered by health insurance when she taught in Central America. She got pregnant there and returned to the United States a little while later. When she came back to the U.S. she was not eligible for COBRA continuation coverage because she had not been insured with a U.S. insurance company.

She tried to get Kentucky Access insurance that is supposed to cover those who have difficulty getting insurance, but they required that she had been a Kentucky resident for previous 12 months. She has not been able to get insurance for her pre-existing condition of pregnancy even though she was insured when she got pregnant. So we are hoping this is a normal delivery with a midwife and that the baby is born healthy. If complications occur, the bills are indeed going to be very high for her and her husband.”

Blade. The widespread industry practice of charging women hundreds of dollars a year more than men of the same age appears to be gender discrimination, the newspaper said in an editorial. For example, a 30-year-old Columbus, **Ohio**, woman pays 49 percent more than a man of the same age for Anthem Blue Cross and Blue Shield's Blue Access Economy plan. At 40, the gap narrows somewhat, with Anthem, a WellPoint Inc. subsidiary, charging women 38 percent more than men for that policy.

- "The insurance gap," Editorial, *Toledo Blade*, November 2, 2008 (<http://toledoblade.com/apps/pbcs.dll/article?AID=/20081102/OPINION02/811020323>)

- Striking new evidence emerged of a widespread gap in the cost of health insurance, as women pay much more than men of the same age for individual insurance policies providing identical coverage, according to new data from insurance companies and online brokers. For example, in **Texas**, women ages 25 to 29 pay 39 percent more than men of the same age when they buy coverage from the Texas Health Insurance Risk Pool. In **Nebraska**, a 35-year-old woman pays 32 percent more than a man of the same age for coverage from the state insurance pool.

- "Women Buying Health Policies Pay a Penalty," Robert Pear, *The New York Times*, October 30, 2008 (www.nytimes.com/2008/10/30/us/30insure.html)

- The **California** agency that oversees health maintenance organizations opened an investigation into one insurer, Blue Cross of California, a subsidiary of WellPoint Inc. The Department of Managed Health Care discovered that Blue Cross had a department dedicated to finding ways to deny coverage and cancel policies for pregnant women and the chronically ill.

- "And they thought they had insurance...." Hector De La Torre and Anmol S. Mahal, *San Francisco Chronicle*, October 12, 2007 (www.sfgate.com/cgi-bin/article.cgi?file=/c/a/2007/10/12/ED36SN75F.DTL)

- "In July 2004, my husband and I applied for personal health insurance from Anthem Blue Cross and Blue Shield of **Virginia** [a subsidiary of WellPoint Inc.]. He had left his job to start his own company, and I was self-employed, so we began looking for family coverage while the COBRA clock ticked. Because I was blessed with lifelong health, the 'medical information' page of my application was relatively brief. I listed a prescription for Clomid, a fertility drug I'd taken while trying to conceive my daughter, and a single appointment I'd had with a psychiatrist after she was born, regarding the possibility of postpartum depression. Shortly after we submitted our paperwork to Anthem's headquarters in Roanoke, the letters started arriving in our mailbox. My application was under review. More information was needed. Then another letter arrived. My husband and 9-month-old daughter had been approved for coverage at Level 1, the company's best rating. I had been rejected. The reason: the psychiatrist appointment."

- "Pricey Therapy; The downside of making postpartum depression sexy," Whitney Morrill, *Slate.com*, August 30, 2005 (www.slate.com/id/2125233/)

4. Insurers Wrongfully Drop People's Coverage

Insurance companies don't like it when their customers get sick and cut into their profits. A typical response is to boot the policyholder out of the plan. For example:

- According to the *Los Angeles Times*, **California's** Health Net Inc. "avoided paying \$35.5 million in medical expenses by rescinding about 1,600 policies between 2000 and 2006." This secret came out when a hairdresser fought back after Health Net dropped her during her chemotherapy. Now, California is investigating the state's top health plans – and finding that Health Net wasn't the only one ripping up people's policies.
 - "Health insurer tied bonuses to dropping sick policyholders," *Los Angeles Times*, Lisa Girion, November 9, 2007 (www.latimes.com/business/la-fi-insure9nov09_0,4409342.story?track=mostviewed-storylevel)
- Anthem Blue Cross (then known as Blue Cross of **California**), a subsidiary of WellPoint Inc., asked doctors to help the insurer find medical conditions that would justify cancellation of patients' coverage. After doctors protested and ignited a public uproar, the company stopped sending out the letters.
 - "Blue Cross Halts Letters Amid Furor," *Los Angeles Times*, Lisa Girion and Jordan Rau, February 13, 2008 (www.latimes.com/business/la-fi-bluecross13feb13_0,4778416.story)
- Five months after a mountain-bike accident left Heidi Bleazard, of **Utah**, with a broken back and a severe head injury, Regence Blue Cross Blue Shield retroactively cancelled her policy. Such "post-claims underwriting" practices have come under fire across the country and been the subject of a congressional investigation.
 - "Utah couple testifies on yanked coverage," Matt Canham, *Salt Lake Tribune*, July 17, 2008 (www.instituteforlegalreform.com/index.php?option=com_ilr_news&id=I2749063803&view=article&Itemid=30&format=pdf)
- According to the insurance industry's own estimate, thousands of rescission investigations into policy holders occur every year, and most of them lose all their coverage as a result. According to **Connecticut** Attorney General Richard Blumenthal "These incidents are hardly isolated and random -- they are part of a pattern, a prevalent practice in this industry."
 - "Battling Blinding Disease and Insurance Company," ABC News, June 18, 2007 (<http://abcnews.go.com/GMA/story?id=3289308&page=1>)
- On March 25, 2009 a class action lawsuit was filed in the federal court in **California** alleging that WellPoint Inc., owner of Blue Cross Blue Shield franchises in 14 states, engaged in a conspiracy with other health insurers to underpay physicians for out-of-network services,

Their Abuses, Our Pain

Parvin Mottaghi of Los Angeles was left with \$100,000 in medical bills after her insurance company abruptly cancelled her policy, prompting her to file a lawsuit, according to news reports.

Parvin completed the Blue Shield application on Sept. 14, 2005. In her application she disclosed that she had respiratory problems, specifically bronchitis. Blue Shield approved coverage on Oct. 1, 2004. On Feb. 24, 2005, Parvin went to the Center for Interventional Cardiology and Nephrology for a nuclear cardiology study. Blue Shield approved the exam. After numerous tests, Parvin's doctors determined that she needed surgery for a defective heart valve. Blue Shield authorized the surgery, which was performed on Sept. 1, 2005.

Blue Shield cancelled her coverage on March 21, 2006, leaving Parvin with about \$100,000 in medical bills and no prospect of finding a policy from another insurer.

with financial consequences to both physicians and their patients. Similar lawsuits were filed against Aetna Inc. and Cigna Corp. in February 2009. The three lawsuits allege a conspiracy with Ingenix, a division of UnitedHealth Group Inc., to fix prices and set artificially low prices to be paid to non-participating physicians. The lawsuits followed an investigation by New York Attorney General Andrew Cuomo demonstrating intentional rigging of the Ingenix database to shortchange reimbursements. The American Medical Association, California Medical Association, Connecticut State Medical Society and Medical Association of Georgia have joined the WellPoint actions.

The practice of canceling medical coverage after policyholders have become sick or injured cost insurers millions of dollars in fines and settlements. Now, for the first time, a jury will weigh whether an insurer owes anything to a canceled policyholder. The case pits a former Cypress man against the health insurer that dropped him after a disabling car accident. Steve Hailey, a former self-employed machinist, and Blue Shield of California will be directly affected by the outcome, but the case already has influenced how insurers in California handle these rescissions.

- "Blue Shield health insurance rescission case to go to trial," Lisa Girion, *The Los Angeles Times*, May 17, 2009 (www.latimes.com/business/la-fi-rescind18-2009may18,1,5863726.story)
- Anthem Blue Cross, California's largest for-profit health insurer, agreed to pay a \$1-million fine and offer new coverage—no questions asked—to 2,330 people it dropped after they submitted bills for expensive medical care. As part of a deal that the **California** Department of Insurance, Anthem also offered to reimburse those people for medical expenses that they paid out of pocket after they were dropped. The company, a subsidiary of Indianapolis-based WellPoint Inc., estimated that those reimbursements could reach \$14 million.
 - "Anthem Blue Cross agrees to take back clients, pay \$1-million fine," Lisa Girion, *Los Angeles Times*, February 11, 2009 (www.latimes.com/news/local/la-fi-bluecross11-2009feb11,0,5806275.story)
- **California** insurance regulators reached an agreement with insurer Blue Shield to provide new health coverage to 678 consumers whose policies were improperly canceled. The settlement resolved a 2007 lawsuit filed by the state insurance commissioner after Blue Shield rescinded policies over a five-year period that ended in May 2008. The deal requires Blue Shield to reimburse the consumers for medical expenses incurred because of the cancellations. The insurer also was required to change its underwriting and claims practices and set up a third-party review process to rule on future policy rescissions.
 - "Calif. reaches settlement with Blue Shield," Samantha Young, *The Associated Press State & Local Wire*, January 7, 2009 (<http://cbs5.com/business/blue.shield.settlement.2.901688.html>)
- One of **California**'s largest health insurers reached a \$25 million agreement with regulators in an effort to right the wrong of canceling coverage for nearly 1,000 policyholders when they tried to make use of their policies. Health Net Inc. agreed to offer new coverage to 926 customers who were illegally dropped from individual or family policies since 2004.
 - "Health Net, state reach \$25M settlement," *Long Beach Press-Telegram*, September 13, 2008 (http://nl.newsbank.com/nl-search/we/Archives?p_product=LB&p_theme=lb&p_action=search&p_maxdocs=200&p_topdoc=1&p_text_direct-0=1232F15675B23358&p_field_direct-0=document_id&p_perpage=10&p_sort=YMD_date:D&s_trackval=GooglePM)
- **California** regulators admitted that for more than a year they didn't even try to enforce a million-dollar fine against health insurer Anthem Blue Cross, a subsidiary of WellPoint Inc., because they knew they would be outgunned in court. In early 2007, the Department of

Managed Health Care pledged to fine the state's largest insurer for "routinely rescinding health insurance policies in violation of state law." But it never did.

- "State didn't try to collect fine from Blue Cross: Health care enforcers admit they knew they'd be outgunned in court,' Shaya Tayefe Mohajer, *San Francisco Chronicle*, July 4, 2008 (www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2008/07/03/BUSB11JV3B.DTL)
- As a way to increase their profits, health maintenance organizations in **California** told policyholders they were covered for treatment -- and then canceled the policy after the treatment was provided. A Murietta, Calif., family whose child was diagnosed with a potentially fatal tumor in her jaw had health insurance, but when the bills started piling up, the HMO refused to pay and eventually canceled the policy. A Riverside woman with health insurance was denied coverage by her insurer company for giving birth to her child in the wrong hospital, even though it was a facility approved by her HMO.
 - "And they thought they had insurance....," Hector De La Torre and Anmol S. Mahal, *San Francisco Chronicle*, October 12, 2007 (www.sfgate.com/cgi-bin/article.cgi?file=/c/a/2007/10/12/ED36SN75F.DTL)
- A \$200,000 penalty against California Blue Cross, a subsidiary of WellPoint Inc. that is now known as Anthem Blue Cross, is the first in a continuing probe of allegations that the **California** insurer illegally dumped sick patients. The agency is continuing to investigate complaints from consumers who held individual policies, as well as allegations that Blue Cross, its rival Blue Shield, Kaiser Permanente and other insurers routinely cancel policies for inadvertent or irrelevant omissions on applications for coverage.
 - "Blue Cross Faces Fine for Voiding Policy," Lisa Girion, *Los Angeles Times*, September 22, 2006 (<http://pqasb.pqarchiver.com/latimes/access/1132602621.html?dids=1132602621:1132602621&FMT=ABS&FMTS=ABS:FT&date=Sep+22%2C+2006&author=Lisa+Girion&pub=Los+Angeles+Times&desc=Blue+Cross+Faces+Fine+for+Voiding+Policy%3B+The+%24200%2C000+penalty+is+the+first+in+a+continuing+probe+of+allegations+that+the+insurer+illegally+dumped+sick+patients.&pqatl=google>)
- An employee of **California** Blue Cross (now Anthem Blue Cross, a subsidiary of WellPoint Inc.) testified in secret that the state's largest health-plan company routinely canceled policies of sick members after looking for inconsistencies—not fraud—in their applications. State law allows only deliberate omissions or misstatements as grounds for canceling health coverage. The testimony, given in a lawsuit against Blue Cross, also indicated that those reviews were triggered by claims for treatment of certain illnesses. The suit is one of many filed by a Claremont lawyer representing policyholders who say the company seized on inadvertent errors and omissions in applications to justify dumping them after receiving claims, leaving them with big medical bills and no health coverage.
 - "Scrutiny of Sick Patients Is Detailed," Lisa Girion, *Los Angeles Times*, April 26, 2006 (<http://articles.latimes.com/2006/apr/26/business/fi-bluecross26>)

5. Insurers Scam People Through Marketing Abuses

Buyer beware when it comes to health insurance coverage. Insurance companies may sound like they are offering you the world when they're really providing coverage that isn't worth the paper it's written on. For example:

- It's especially tough for an independent business person to find good health insurance. An organization like the National Association for the Self-Employed (NASE) should help, right? It turns out that the NASE is a front for MEGA Life and Health and related companies – all of which are the subject of a multi-state investigation and infamous for shady sales practices, leaky-bucket coverage, and unpaid bills that leave customers financially strapped. MEGA has faced fines from **Delaware** to **Washington** state. William Gedwed, Chairman, President, and CEO of MEGA parent company HealthMarkets, sits on the board of America's Health Insurance Plans (AHIP), the industry's main trade group.
 - "It's Enough To Make You Sick," *Business Week*, September 13, 2004 (www.businessweek.com/magazine/content/0437/b3899076_mz021.htm)
 - "MEGA Life & Health Fined \$500,000 For Numerous Violations," Delaware Insurance Commissioner & Department of Insurance, October 10, 2007 (www.delawareinsurance.gov/departments/news/101007-Press-MegaLifeHealthFined.shtml)
 - "MEGA ordered to stop selling certain insurance policies in Washington," Washington Insurance Commissioner, March 2005 (www.insurance.wa.gov/news/dynamic/newsreleasedetail.asp?rcdNum=439)
- Health plans have fired a warning shot at the brokers who sell their products: Stop efforts to save employers money by combining two different types of insurance products, or you could be kicked out of the sales network. They're also asking employers to sign statements saying they will not combine some high-deductible plans with certain types of self-insurance. If they combine such plans or refuse to sign, they could lose coverage. Some brokers complain that insurers are restraining their ability to come up with innovative ways to save employers money and threatening their livelihood if they do. **California** Insurance

Appealing for Coverage

Jane H., a freelance editor in New York, experienced high out-of-pocket costs and denials of care from the health insurance she was able to buy through a professional association.

"My preferred provider organization (PPO), which 'covers' me and my husband, costs nearly \$500 a month (\$6,000 a year), with a \$3,000 deductible for each of us. After the deductible, we have to pay \$30 for a regular doctor visit and \$50 for a specialist visit. Last fall, I spent a great deal of time appealing denied claims for labs and treatments for a urinary tract infection and then a bad yeast infection, and ended up paying most of what was supposed to be covered myself, so it did not count toward my deductible.

"After that experience, when I fractured several ribs in a running accident I didn't even bother to go to the doctor. Then I fractured my elbow and had to go because, unlike ribs, these bones do not heal themselves. I found that my expensive (at least I think it is) plan covered (with my copayments) the office visits and the X-rays, and would have covered a heavy plaster cast that I couldn't face wearing. It wouldn't cover the removable splint that took the therapist all of half an hour to construct from a piece of steam-heated medical plastic and some glued-on Velcro straps. I had to pay \$1,200 myself for that.

"Then I found out that my plan would cover not a single session of physical therapy, even though my shoulder, arm, elbow, and hand, all of them riddled with scar tissue, would remain useless to the end of my days without it. Apparently, physical therapy is not considered a medical necessity for someone who can only afford \$500-a-month premiums. And so I have been paying for that too."

Commissioner Steve Poizner is looking at the issue, but it appears insurers are acting within their legal rights.

- "Insurers warn brokers: Health plans balk at employers who fill in gaps of high-deductible products," Kathy Robertson, *Sacramento Business Journal*, August 22, 2008
(<http://sacramento.bizjournals.com/sacramento/stories/2008/08/25/story2.html>)
- A health insurer that sells mainly to the self-employed agreed to pay \$20 million—one of the largest fines of its type—to settle violations found by regulators in a **36-state** investigation. The investigation, prompted by numerous complaints, found that insurer HealthMarkets failed to properly train its sales agents, who didn't always fully disclose to consumers the limits of the policies and sometimes did not pay for medical services promptly. The company sells an array of plans, many of which pay only limited amounts toward medical care.
 - "HealthMarkets fined \$20 million after multistate investigation," Julie Appleby, *USA Today*, July 21, 2008
(<http://abcnews.go.com/Business/story?id=5425461&page=1>)

6. Insurers Defraud Taxpayers

Insurance companies make big money from taxpayer-funded programs such as Medicare and Medicaid. Some insurers try to increase profits by defrauding the government. For example:

- A **New York** investigation uncovered managed care companies charging duplicate premiums and billing for dead and fake patients.
- Americhoice of **Pennsylvania** – now part of UnitedHealth Group Inc. – settled charges it misled the state about claims, dragged its feet with payment to providers, and denied patients care they had a right to receive.
 - “Medicare, Medicaid Managed Care Gets Scrutiny for Fraud,” *The Wall Street Journal*, March 19, 2008 (http://online.wsj.com/article/SB120589320981247561.html?mod=googlenews_wsj)
- Tampa-based WellCare Health Plans Inc. engaged in a scheme to defraud the **Florida** Medicaid program and Florida Healthy Kids Corporation of about \$40 million. Florida's largest Medicaid managed care provider will be allowed to avoid criminal prosecution for health care fraud if it pays \$80 million in restitution, under an agreement with the U.S. Attorney's Office.
 - “WellCare to pay \$80 million; may avoid conviction,” Christine Armario, Associated Press, May 5, 2009 (www.miamiherald.com/news/florida/AP/story/1033264.html)
- Administrators of the struggling North Carolina State Health Plan did not inform legislators for at least four months last year about multimillion-dollar financial problems, according to the state auditor's office. Administrators of the plan, which insures 667,000 teachers, state employees and retirees, underestimated revenues and claims, creating a nearly \$80 million loss last year, the audit said. Auditors criticized the plan's leaders, who have been

Medicare Enrollee Denied Care

Ray C. of Trabuco Canyon, Calif., described his mother's experience after joining a private Medicare Advantage health plan.

"My mother got fast-talked into joining a private Medicare HMO instead of keeping the public Medicare plan she always had. 'Look at all the extra benefits you get as compared with Medicare,' she was told by a slick HMO salesperson at a neighborhood meeting. She lived independently in her own home in good health until one night she slipped and broke her hip and was hospitalized for surgery.

The story after that was the same for almost a year: the HMO was there at every juncture fighting to deny or delay the care she needed. They kicked her out of the hospital before she was ready, then tried to cut short her rehab in the nursing home, bringing in their own doctors to pressure the nursing home staff into saying she was ready for discharge when she couldn't yet walk, and had infections contracted in the low-bid facilities they had placed her in. 'The HMO booklet says she is covered for 100 days in the nursing home,' I pointed out. 'That's only if she's making progress,' the HMO countered, 'and our doctors say she isn't making progress.' But she could not progress in her physical therapy until the infections had subsided, and the HMO refused to acknowledge that or allow any more time.

I filed an external appeal with Medicare and won an extra 60 days in the nursing home for her, but the HMO refused to give her physical therapy so she was confined to her bed and contracted bed sores, bladder infections, and pneumonia. At the end of the 60 days, the HMO was again insisting she was ready to be discharged, when she could not get out of bed and required a nasal feeding tube! Another appeal to Medicare forced them to keep her in the nursing home until the tube could come out.

Repeated trips to the hospital emergency room due to nursing home-contracted infections forced the HMO to grant my mother additional 21-day stays in the nursing home. After nearly one year of unsuccessfully fighting this broken, inhumane system to get the care she needed, I lost my mother in January of 2007. After being denied necessary care and treatment at every turn, she died in the nursing home from pneumonia she contracted there. I blame the HMO."

replaced, for agreeing to a contract with Blue Cross Blue Shield of **North Carolina** that gave the insurance company no incentive to contain costs and that was not reviewed by a contract lawyer or contract professional. The auditors warned that the contract creates a potential conflict of interest. Lawmakers bailed out the plan for the current year with a \$250 million infusion.

- "Health Plan's trouble long kept quiet," Mark Johnson, *Raleigh News & Observer*, May 1, 2009 (<http://www.newsobserver.com/news/story/1508695.html>)
- Anthem Health Plans of **Kentucky** Inc., a subsidiary of WellPoint Inc. agreed to pay back \$1.25 million in overcharges to 43,000 seniors and disabled individuals enrolled in its Medicare Select products under an agreement reached with the Kentucky Office of Insurance. In addition, Anthem Health Plans agreed to arrange for the Anthem Foundation, the company's charitable arm, to contribute \$1 million to a number of senior- and health-related organizations.
 - "Office of Insurance, Anthem Health Plans Reach Settlement; Insurer to pay \$1.25 million to 43,000 covered under Medicare Select products," Press Release, Kentucky Office of Insurance, October 2, 2006 (<http://migration.kentucky.gov/Newsroom/doi/anthemsettle2006.htm>)
- **Kentucky** ordered Anthem Health Plans, a subsidiary of WellPoint Inc., to refund \$23.7 million in overcharges to more than 81,000 elderly or disabled individuals, Governor Ernie Fletcher announced. In addition, the state is fining the company \$2 million for overstated projections and for failure to notify the agency when the errors were discovered. This is the largest fine ever levied against an insurer by state regulators.
 - "Anthem directed to refund \$23 million to 81,000 elderly, disabled in Kentucky; Office of Insurance action related to company's Medicare supplement insurance," Governor Ernie Fletcher's Communication Office, Press Release, November 22, 2005 (<http://migration.kentucky.gov/Newsroom/agovernor/051122koianthemmedicare.htm>)
- A WellPoint Inc. subsidiary, AdminaStar Federal, agreed to pay \$6 million to the federal government to resolve whistleblower accusations of rampant Medicare fraud over a seven-year span in the 1990s. The Indianapolis-based company administers and processes Medicare claims in 10 states and Washington, D.C. Most of the problems occurred in **Kentucky**.
 - "WellPoint Company Slapped over Medicare," Tom Murphy, *Indianapolis Business Journal*, October 3, 2005 (www.allbusiness.com/government/government-bodies-offices-us-federal-government/10576160-1.html)
- Anthem Blue Cross and Blue Shield, a subsidiary of WellPoint Inc., agreed to pay \$1.5 million to settle allegations that it overcharged the **Federal Employee Health Benefits Program** by including "impermissible profit" in its charges. According to the Justice Department, the overcharges came between 1992 and 2002, and the company failed to pass on to the Office of Personnel Management the full amount of its share of money from drug company rebates.
 - "FEHBP contractor agrees to pay \$1.5 million settlement," Karen Rutzick, *Government Executive*, August 23, 2005 (www.govexec.com/story_page.cfm?articleid=32086)
 - "Anthem Insurance Cos. To Pay U.S. \$1.5 Million for Overcharging Federal Employee Health Benefits Program," U.S. Department of Justice, Press Release, August 8, 2005 (www.usdoj.gov/opa/pr/2005/August/05_civ_412.htm)
- Empire HealthChoice Assurance is refunding and providing premium credits totaling over \$23.3 million to Medicare Supplement customers. **New York** regulators determined that the

ratio of claims paid relative to premiums charged from 2000 to 2002 fell below legal standards.

- "Empire HealthChoice Assurace Reimbursing over \$23 Million to Medicare Supplement Policyholders; Credits and Refunds Determined after Review of Loss Experience," New York State Insurance Department, Press Release, November 26, 2003 (www.ins.state.ny.us/press/2003/p0311261.htm)
- Blue Cross of **California** and its parent company, WellPoint Health Networks, agreed to pay the United States \$9.3 million to resolve allegations that it defrauded Medicare. The insurer, which was under contract with the Centers for Medicare & Medicaid Services to process claims in California until December 2000, is alleged to have knowingly falsified data regarding its preparation of cost report audits for Medicare.
 - "Blue Cross of California and WellPoint Health Networks to Pay U.S. \$9.25M to Settle Allegations of Medicare Fraud," Press Release, U.S. Department of Justice, July 29, 2002 (www.usdoj.gov/opa/pr/2002/July/02_civ_435.htm)
- Blue Cross and Blue Shield of **North Carolina** says it is taking seriously allegations that one of its lobbyists tried to bribe a state representative in exchange for killing a bill. A letter alleging a violation was sent to House Speaker Joe Hackney by the State Employees Association of North Carolina. The General Assembly's ethics committee said two weeks ago that it received the allegation but identified neither the lobbyist nor the legislator. The head of the state-employee association, Dana Cope, claims that the lobbyist is a Blue Cross employee.
 - "NC Blue Cross taking seriously bribery allegation," *Associated Press*, May 19, 2009 (www.forbes.com/feeds/ap/2009/05/19/ap6443492.html)

7. Insurers Paid Bounties to Employees for Denying Coverage

Insurance companies reward employees who help them get rid of risky members. For example:

- Health Net Inc., a California-based insurance company, saved \$35.5 million by dropping 1,600 policyholders when they most needed health care. To achieve those savings, the company gave its employees bonuses based in part on how many members they dropped and how much money was saved. The company paid its senior analyst in charge of cancellations more than \$20,000 in bonuses.
 - "Health insurer tied bonuses to dropping sick policyholders," *Los Angeles Times*, Lisa Girion, November 9, 2007 (www.latimes.com/business/la-fi-insure9nov09,0,4409342.story?track=mostviewed-storylevel)

Rare Diagnosis Threatens Coverage

Shannon Dagher, a California college student, told ABC's Good Morning America that her insurance company wanted to rescind her coverage when she got sick.

In a June 18, 2007, interview, the 22-year-old college student said she was at the eye doctor for a checkup one month after her new insurance policy kicked in, when she received terrible news.

"I was diagnosed with a very rare disorder, called pseudotumor cerebri. It basically looks and acts like a brain tumor," Dagher said. Dagher's doctors said she needed surgery or she may go blind.

"I'm petrified of the thought of going blind," Dagher said. "I've never been sick before in my life and now in the past six months I've started to lose my peripheral vision and I'll never get that back."

But instead of authorizing the surgery Blue Cross of California, a subsidiary of WellPoint Inc., stopped processing her bills. The company launched a "rescission investigation" and threatened to cancel her coverage for failing to disclose accurate information about her health on her original application.

Her Blue Cross application asked about headaches (which can be a sign of pseudotumor cerebri) as well as more serious conditions like epilepsy, paralysis and stroke all in one question. Dagher didn't have any of those serious conditions, so she checked no.

"I never lied to Blue Cross on my application," she said. "At the time I got insurance I had no idea something was wrong with me."

8. Insurers Export Dollars Over State Lines to Help Affiliated Companies

Many insurers are owned by out-of-state holding companies. Money from subsidiaries sometimes is siphoned out of the area to bolster the parent company's bottom line, and the lines between nonprofit and for-profit companies may be blurred. For example:

- In 2008, Premera Blue Cross funneled surpluses to a failing for-profit subsidiary in **Arizona** while raising rates for Washington customers. From the Seattle Post-Intelligencer: "Statements filed with the Washington State Insurance Commissioner's office indicate Premera transferred \$49 million to the struggling LifeWise Health Plan of Arizona between 2004 and 2007. Although the transfers aren't illegal, they've raised concerns that the nonprofit company is raising rates for Washington residents to subsidize an out-of-state, for-profit venture."

- "Premera surpluses here subsidize Arizona losses," Brian Slodysko, *Seattle Post-Intelligencer*, February 24, 2008 (http://seattlepi.nwsource.com/local/352562_insurance25.html)

- **Rhode Island's** United Healthcare of New England wanted to send \$36.8 million as an "extraordinary dividend" to its **Minnesota**-based parent company, a subsidiary of UnitedHealth Group Inc., (the center of a recent stock options scandal). Less than a year earlier, the insurer had shipped off \$17 million to its parent company. The two dividends would have amounted to more than half of the insurance company's roughly \$90 million surplus, prompting the state's Health Insurance Commissioner to step in. After a firestorm of public protest, United Healthcare withdrew its proposal – but how much money gets shifted to corporate parent profits under the radar?

- "United HealthCare's \$36.8 million to stay in RI, for now," Press Release, Office of the State Insurance Commissioner, State of Rhode Island, March 2007 (www.ohic.ri.gov/documents/Insurers/Regulatory%20Actions/2007%20Extraordinary%20Dividends%20Request/Press%20release%20-%20United%20Withdraws%20Request.pdf)

Cataract Surgery Denied

Marlene Z. of Indianapolis shared her story of being denied coverage for needed care, illustrating how cheap insurance companies can be with their members, while being so generous with their parent companies.

"I am a retired Licensed Clinical Social Worker, retired certified chemical dependency counselor, and still active RN in the mental health field. I had two situations in which an insurance procurer provided insurance with 'no pre-existing clause' to the non-profit organization where I worked. Shortly after my coverage started—after four months of paying a premium—my cataracts, which can grow fast or slow, made a leap in growth and had to be removed. After I had cataract surgery, even though coverage had been confirmed by my doctor and by me separately, the insurance company refused to cover the surgeries, claiming the cataracts were a pre-existing condition.

Later I had a severe gall bladder attack and needed surgery. Again the insurance company refused to pay claiming it was a pre-existing condition. That was a surprise to my own doctor.

Those are the worst of my personal stories, but as a healthcare professional I have witnessed many such tragic situations."

9. Insurers Reward CEOs for Bad Practices

Insurance company CEOs are raking in the dough. In 2007, the average value of CEO compensation packages for the top 10 for-profit health insurance companies was \$11.9 million, ranging from \$1.6 million to \$25.8 million. For example:

- In 2006, UnitedHealth Group Inc. CEO William McGuire found himself in hot water with the U.S. Securities and Exchange Commission over improper backdating of stock options, maneuvers designed to maximize the value of shares they are sold at a steep discount. He forfeited \$620 million in stock options and retirement compensation and resigned. But he kept options valued at \$800 million and received \$530 million in compensation from 1991 to 2006 from the Minneapolis, **Minnesota**-based company.
 - “Options Backdating Claims UnitedHealth CEO,” Chris Arnold, NPR, October 16, 2006 (www.npr.org/templates/story/story.php?storyId=6278287)
- In 2003, Blue Cross and Blue Shield of **Montana**’s CEO, Peter Babin, told the public not to fuss over his \$1.4 million compensation package, including dog-sitting services, first-class travel for him and his wife, and a \$2,500 annual dining expense account. He called public questioning of his compensation “petty” – and later resigned.
 - “Blue Cross CEO earns \$525,000,” Charles S. Johnson, IR State Bureau, October 18, 2004 (www.helenair.com/articles/2004/10/18/montana_top/a01101804_01.txt)

10. Insurers Deny Emergency Care

The Emergency Medical Treatment and Labor Act requires health care providers to give emergency care to everyone who needs it, regardless of ability to pay or insurance status. However, health plans are not required to pay for emergency care, and some have created administrative and financial barriers that prevent patients from getting the emergency care they need. For example:

- In **California**, Kaiser Permanente was fined \$1.1 million for "systemic problems" with the health plan's emergency care procedures, which resulted in three patient deaths.
- In 2001, several patients in **Utah** sued the Intermountain Health Care insurance plans for regularly denying emergency billings without reviewing patients' medical records.
- In 2002, PacifiCare of **Arizona**, now a subsidiary of UnitedHealth Group Inc., was fined \$125,000 for more than 1,000 violations of state laws governing health plans, including unfairly denying claims for emergency care between 1996 and 1998. PacifiCare paid the fine without challenging the state's findings.
- In 2002, patients in **Ohio** received bills because the emergency physicians did not participate in their health plans, even though the hospitals were "in-network."
- In 2001, Blue Cross Blue Shield of Rochester, **New York**, agreed to pay hospitals for 25,000 emergency department claims it had denied between 1997 and 2000, worth potentially \$1 million.
- In 2001, **Colorado** fined the Rocky Mountain Health Maintenance Organization \$40,000 for improperly handling claims, including ones for emergency care.
- In 1999, **Florida** fined five managed care organizations a total of \$1 million for denying reimbursement and delaying payments for hospital emergency department claims.
- In 2000, **Washington** fined Premera \$55,000 for improperly discouraging people from seeking emergency care. In 1999, the state fined Qual Med \$25,000 for improperly denying emergency claims and ordered the health plan to pay the claims.
 - "Managed Care: Do health plans create barriers to obtaining emergency care?" American College of Emergency Physicians (www3.acep.org/patients.aspx?id=26094)
- The **California** Supreme Court ruled that emergency room doctors who think a patient's health maintenance organization underpaid them can't bill the patient for the difference and must seek redress from the health plan. The case involves common type of fee dispute, over

Lawyer Wins Coverage Dispute

Angelo Bellomo of Sherman Oaks, Calif., shared her experience being denied coverage for her emergency room visit.

"I went to the hospital with chest pains and light headedness. I followed the blue 'Hospital' signs to the nearest hospital. When I got there, the doctor told me it was a mild inflammation in my rib tissue. I told him it felt deeper. He explained that inflammations in the tissue can 'take to' surrounding muscles creating the illusion of a deeper problem. He sent me on my way with Bayer.

The next day I got a call from the hospital telling me my tests showed my lung was collapsing, and to get there as soon as possible. After arriving, I was told I had to go to a hospital that participated with my insurance plan. I went there and was treated. I recovered nicely.

A few weeks later I start getting bills from the radiology department and emergency room. I sent them to my insurance company, which denied payment because the services were rendered at a non-plan facility. I was shocked! It took months of letter writing and stress to get them to agree to pay those bills, which they only did after I had a lawyer friend write some very firm letters."

the cost of caring for HMO members who receive emergency care at hospitals that don't have contracts specifying the amount the health plans will pay them. The scope of the problem was illustrated by state regulators' pending lawsuit against Prime Health Care, which owns a group of hospitals in Southern California. The company sent bills to 6,000 Kaiser Permanente customers last year for amounts the HMO had refused to pay for emergency and post-stabilization care.

- "Patients off hook for emergency room fees; Any dispute is between doctor and HMO, justices rule," Bob Egelko, *San Francisco Chronicle*, January 9, 2009 (www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2009/01/09/BAF91568UK.DTL&hw)

- The **North Carolina** insurance commissioner ordered Blue Cross and Blue Shield of North Carolina to pay a civil penalty of \$1.9 million for making underpayments on emergency claims.

- "Blue Cross Must Pay \$1.8 Million Fine For Claims Underpayments," WRAL, Capitol Broadcasting Company, Inc., December 18, 2003 (www.wral.com/news/local/story/1090303/)

11. Insurers Overcharge Small Businesses

Insurance companies often raise rates as much as the market will bear, leaving small businesses vulnerable because they have little negotiating leverage. For example:

- After large premium increases in 2005 and 2006, the Harris County Medical Society in Houston invoked its rights under state law and asked **Texas** Blue Cross and Blue Shield, a subsidiary of Health Care Service Corp., to release the society's claims history. The law requires health plans to disclose the share of premium revenue spent on health care, a statistic known as the medical loss ratio. The medical group was offering its 21-member staff a preferred provider organization product and a high-deductible plan with a health savings account. In 2006, the PPO raised the medical society premium 22.4 percent even though the plan paid out only 67 percent of premiums for care. The HSA in 2006 increased its premium by 21.7 percent despite paying out only 9 percent of premium dollars for care the previous year.

- "Where's the Money Going? Physicians Want Employers to Ask How Premium Dollars Are Spent," *Texas Medicine*, May 2008 (www.texmed.org/Template.aspx?id=6699)

- Georgia's largest health insurer, Blue Cross and Blue Shield of **Georgia**, a subsidiary of WellPoint Inc., was hit with a \$600,000 state fine for violations that included refusing to offer insurance price quotes to some small businesses.

- "Health insurer fined for refusing to offer quotes to some firms," Andy Miller, *Atlanta Journal-Constitution*, October 26, 2006 (www.accessmylibrary.com/coms2/summary_0286-22313997_ITM)

Health Plans Hit Small Employers

Karen Q. of Glendale, Ariz., said she struggles to get and keep health insurance for her family as a small business owner.

"As a small business owner and someone with a pre-existing condition, I know firsthand how difficult and expensive it is to obtain health insurance. This is just morally wrong. We are at the mercy of our health insurance company since no other company will touch us. Consequently, we endure 30 to 40 percent increases every year. Insurance for my husband, my son and myself is approximately \$2,000 per month. Insanity!"

12. Insurance Companies Collude With Providers to Drive Up Prices

What happens when an insurance oligopoly does business with a provider conglomerate? Prices go up for everybody. For example:

- In May 2000, Partners HealthCare and Blue Cross Blue Shield of **Massachusetts** made a deal to give Partners doctors and hospitals the biggest insurance payment increase since Massachusetts General and Brigham and Women's hospitals agreed to join forces in 1993. In return, Partners agreed orally to not allow any other insurer to pay less. The deal marked the beginning of a period of rapid escalation in Massachusetts insurance prices, as Partners repeatedly used its clout to get rate increases and other hospitals tried to keep up.
 - "A Handshake That Made Healthcare History," Scott Allen, Marcella Bombardieri, Michael Rezendes, *The Boston Globe*, December 28, 2008 (www.boston.com/news/health/articles/2008/12/28/a_handshake_that_made_healthcare_history/)

Rules Designed to Confuse

Alison Bass wrote in the *Boston Globe* about her family's inability to afford the medical care it needs.

"The nearly 300,000 Massachusetts residents who signed up for health insurance under the state's new initiative are in for a rude awakening. They may now have some form of coverage, but many of them, even the very poor who used to get free care, are going to be socked with steep medical bills..."

"By last fall, [my family] owed nearly \$3,000 in medical expenses. The bills had begun accumulating shortly after my husband, a social worker, switched jobs and we were forced to change health insurance from a local Blue Cross plan to a for-profit national plan. My husband was not offered a choice of health plans, and when we signed up it was not made clear that our deductible for the year would be \$3,000 (for in-network expenses; \$4,500 for out-of-network).

"Nor did we understand that once we met the deductible (i.e., spent \$3,000 to \$4,500 of our own money), we would then have to pay co-insurance: 15 percent of every in-network expense we incurred and 45 percent of any out-of-network expenses..."

"Instead of counting the full amount of our medical bills toward the deductible, the company only included a lower 'discounted' amount and excluded the cost of our co-insurance charges. According to the Access Project, such tactics are not that unusual. But they often go unnoticed because of the sheer complexity of the system. This experience has taught me that our system of private health insurance is badly broken and individual states cannot institute reform alone. We need universal healthcare on a federal level..."

-- Jan. 21, 2008

http://www.boston.com/bostonglobe/editorial_opinion/oped/articles/2008/01/21/an_underinsured_kick_in_the_groin/

13. Insurers Prevent Doctors from Delivering Care They Feel Is in the Best Interest of Their Patients

Insurance companies pressure doctors to alter the way they treat their patients. For example:

- A survey of doctors by the Medical Society of the State of **New York** found that of 1,200 physicians surveyed, 90 percent said they have had to change the way they treat patients based on restrictions from an insurance company; 92 percent said insurance company incentives and disincentives regarding treatment protocols “may not be in the best interest of the patients”; 87 percent said that they sometimes feel they are pressured to prescribe a course of treatment based on cost rather than on what may be best for the patient; 78 percent said that an insurance carrier has restricted their ability to refer patients to the physicians they believed would best treat their patients’ needs; 62 percent are either somewhat concerned or very concerned (37 and 25 percent, respectively) that they may be cut out of an insurance network if they do not follow the policies of the insurance companies.

- “Survey Reveals that Doctors Feel Pressured by Health Insurers to Alter the Way They Treat Patients,” Press Release, Medical Society of the State of New York, September 2008 (www.mssny.org/mssnyip.cfm?c=i&nm=Insurance_Carrier_Rules)

- When Tufts Health Plan cut a patient's prescription for the sleep aid Lunesta from 30 pills to 10 pills a month, her physician, Dr. Stephen A. Hoffmann, decided to circumvent **Massachusetts** regulations by writing a second prescription in the name of her husband so she could get 10 more pills per month. Hoffmann is aware that by publicly acknowledging the prescription ploy, he could be subject to disciplinary action and even criminal charges. But he considers himself a "medical conscientious objector" and says a patient's welfare comes before what he believes are unreasonable insurance restrictions.

- “Fed-up doctor sidesteps insurance company limits,” Christopher Rowland, *The Boston Globe*, June 11, 2006 (www.accessmylibrary.com/coms2/summary_0286-16996424_ITM)

- A recent survey conducted by the American College of Allergy, Asthma and Immunology found that 95 percent of allergists surveyed believe that health insurance changes are hindering their ability to provide the best possible care to their patients.

- “Managed care problems: William Berger, M.D.,” *USA Today*, July 28, 2003 (www.usatoday.com/community/chat_03/2003-07-28-berger.htm)

Denials Interfere With Care

Lucy Gorham of Chapel Hill, N.C., said her insurance company has interfered with a doctor’s treatment plans for her husband.

“My husband has Parkinson's and is under the care of a nationally-respected doctor at Duke. His health insurance recently denied coverage for two of his medications, arguing at one time that they duplicated one another and at another time that they were incompatible with each other.

“The doctor disagreed and sent the insurer a letter, and then their own form, stating this and requesting an override. It has taken his doctor, his nurse, me and my husband, and a health advocate more than a month to clear up this mess. And we wonder why health care is so expensive when doctors have to spend their time dealing with insurance bureaucracies that shouldn't be making these decisions in the first place.”

14. Insurers Delay Reimbursement to Patients and Providers

Insurance companies create administrative hurdles—even break the law—to prevent prompt payment of medical bills. They delay payment as long as possible because they can make money by holding the cash longer. It must be profitable because they do it, get caught, pay a fine, and then do it all over again. For example:

- An examination by the **Georgia** insurance department found that United Healthcare was late with more than 75,000 claims under Georgia's prompt-payment law. In response to the findings, Georgia fined United Healthcare and sister companies United Healthcare of Georgia Inc. and Golden Rule Insurance Co., \$2.8 million. The company was fined for similar delinquencies in 2000 and 2002.

- "United Healthcare fined," Carly Farrell, *Americus Times-Recorder*, January 3, 2006 (www.americustimesrecorder.com/local/local_story_003234020.html)

- The **Texas** Department of Insurance fined United Healthcare, a subsidiary of UnitedHealth Group Inc., \$4.4 million for violating the state's prompt payment law. In the state's 2007 action, officials said the company did not pay "clean" claims on time. It was the second time in two years and the fourth time since 2001 that Texas fined United Healthcare for the same type of violation.

- "TDI Fines United...Again," Texas Medical Association, November 14, 2007 (www.texmed.org/Template.aspx?id=6325)

- The **North Carolina** Department of Insurance found United Healthcare was delaying prompt payment of medical claims and not giving patients the correct amounts. United Healthcare, a subsidiary of UnitedHealth Group Inc., agreed to pay nearly \$800,000 in fines.

- "United HealthCare fined \$800,000," *The News & Observer*, July 24, 2008 (www.newsobserver.com/news/story/1152663.html)

- The **Arizona** Department of Insurance ordered United Healthcare to pay \$364,750 in civil penalties for illegally denying more than 63,000 physician claims without receiving all the information necessary to make the decisions and for failing to follow state laws for promptly notifying doctors and patients about decisions and appeals.

- "United Healthcare fined \$364,750," Scott Simonson, *Arizona Daily Star*, March 11, 2006 (www.azstarnet.com/allheadlines/119565)

- Lodi Memorial Hospital in **California** is suing Anthem Blue Cross, a subsidiary of WellPoint Inc., for more than \$6.3 million it says it was not paid by Anthem even after the insurer had authorized treatment of its patients. In one of several examples cited in the suit, a patient arrived at the emergency room and was admitted. On Oct. 15, 2007, the hospital

Insurance Confusion Grows

Helen McLaughlin of Roswell, Ga., a health care administration worker, said health insurance companies wrap care in red tape.

"Having worked in health care administration for years, I am aware of how much money is spent on non-direct health care expenses, such as processing claims and programming and purchasing billing systems. It's outrageous and frustrating. Additionally, these administrative issues affect the delivery of health care in that health care providers must be trained and retrained in how to complete billing paperwork as new rules are implemented by the payers, and as systems are changed and upgraded. They should not be allowed to continually change the payment rules (i.e., forms, formats, field lengths, codes, etc.) in order to confuse the providers and those who are insured."

contacted Blue Cross and confirmed the patient's insurance. The charges totaled almost \$152,000, but the hospital only received a little less than \$48,000, according to the lawsuit.

- "Lodi Memorial Hospital sues Anthem Blue Cross for \$6.3 million," Layla Bohm, *Lodi News-Sentinel*, May 6, 2009 (www.lodinews.com/articles/2009/05/06/news/5_lmh_090506.txt)
- One **Indiana** medical practice is owed \$30,000 from Anthem Blue Cross, a subsidiary of WellPoint Inc. Another has a 55 percent increase in claim denials from the insurer. Alerted by such reports, Indiana State Medical Association staff went seeking the facts. They researched complaints against Anthem with the Indiana Department of Insurance, contacted members and neighboring state medical societies, and met with leaders of the Indiana Medical Group Management Association. The Anthem team insisted their claims processing performance is improving.
 - "Anthem says it's resolving issues, offers timeline," ISMA e-Reports, Indiana State Medical Association, December 15, 2008 (www.ismanet.org/news/e-reports/2008_Reports/12-15-08/anthem.html)
- Blue Cross Blue Shield of **Georgia**, a subsidiary of WellPoint Inc., was fined \$12 million by the Georgia insurance commissioner on Dec. 4, 2008, for a prompt-payment violation after it was found to have improperly reimbursed out-of-network ambulance providers for transportation services.
 - "Oxendine Orders Blue Cross To Reimburse \$12 Million," Office of the Commissioner of Insurance, News release, December 4, 2008 (www.gainsurance.org/ExternalResources/Announcements/NewsReleaseInsurance-1242008-1127.pdf)
- The Greater Cincinnati Hospital Council (GCHC) and several of OHA's member hospitals have been negotiating with Anthem Blue Cross of **Ohio**, a subsidiary of WellPoint Inc., for months over its inability to timely process and pay hospital and physician bills. Anthem admits to bill processing problems with federal and local insurance products and has repeatedly promised to improve, but with little success.
 - "Memorandum to Ohio Dept. of Insurance," Mary Gallagher & Charles Cataline, Ohio Hospital Association, November 7, 2008 (www.ohanet.org/finance/billing/ODIMemoAnthemBCBS110308.doc)
- United Healthcare of **North Carolina**, a subsidiary of UnitedHealth Group Inc., agreed to pay the state nearly \$800,000 to resolve allegations that the two companies violated state law. The Insurance Department discovered the companies were not settling claims quickly enough and for the correct amounts. The department fined the companies a record \$2.2 million as part of a settlement agreement. After the 2004 settlement, other states began looking into the company and discovered more problems with claims processing, settlement and payment as well as their coordination of benefits; appeals, grievances and complaint resolution; explanation of benefits; provider networks; and management.
 - "United HealthCare fined \$800,000," Staff Reports, *The News & Observer*, July 24, 2008 (www.newsobserver.com/news/story/1152663.html)
- The **New York** state Insurance Department fined 22 health insurance companies more than \$4 million for failing to pay their claims on time.
 - "Fines Hit 22 Insurance Companies," *The Buffalo News*, May 4, 2002 (http://nl.newsbank.com/nl-search/we/Archives?p_product=BN&p_theme=bn&p_action=search&p_maxdocs=200&p_topdoc=1&p_text_direct-0=0F3546CF6F83AA96&p_field_direct-0=document_id&p_perpage=10&p_sort=YMD_date:D&s_trackval=GooglePM)

- A year of computer snafus boiled over Oct. 13 when the St. Francis hospital system declared WellPoint Inc. in breach of its contract because of habitually late payments. St. Francis threatened to cancel its WellPoint contract as of Nov. 2, saying the insurer was not paying it fair rates and failed to pay some claims for more than a year. Mishawaka-based Sisters of St. Francis Health Services Inc. operates 10 hospitals in **Indiana**.
 - "WellPoint's IT woes taking toll; St. Francis contract dispute just the latest problem involving tardy payments," J.K. Wall, *Indianapolis Business Journal*, October 18, 2008 (www.ibj.com/html/detail_page_Full.asp?content=21925)
- For the second time in two years and the fourth time since 2001, the **Texas** Department of Insurance fined United Healthcare \$4 million because "the company did not pay 'clean' claims on time, and did not live up to the promises it made in December 2005 when it was fined for not complying with the law." The commissioner ordered the UnitedHealth Group Inc. subsidiary to file reports that comply with the 2005 order or face an additional \$3 million fine.
 - "TDI Fines United...Again," Texas Medical Association, November 14, 2007 (www.texmed.org/Template.aspx?id=6325)
- Consumers and health-care providers have filed a total of 67,500 complaints against insurance companies in **New York** State alone since its Prompt Payment Law went into effect in January 1998. Insurers are required to pay undisputed claims within 45 days. In 2000, New York regulators announced that the department had issued fines against 21 health insurers totaling \$575,000.
 - "10 Things Your Health Insurer Won't Tell You," SmartMoney.com, August 29, 2005 (www.foxnews.com/printer_friendly_story/0,3566,167394,00.html)
- **Ohio** insurance regulators levied a total of \$545,000 in fines against seven HMOs for violations of prompt payment law. Companies include Medical Mutual, Kaiser Foundation Health Plan, SummaCare, United Healthcare Insurance of Ohio, Employers Health and Medical Insurance Company of Ohio. Medical Insurance, which had \$289 million in 2000 premiums and paid 12% of its claims late, was fined \$60,000.
 - "Seven Ohio HMOs Fined For Paying Claims Late," Bestwire, April 13, 2001 (www.alacrastore.com/storecontent/Business-and-Industry/24823853)
- Three years after **Texas** passed a law that was supposed to guarantee prompt payment for doctors by insurance companies, both sides are struggling to define what constitutes a prompt payment. In July, Dr. Barry Williams treated a woman for a minor illness. He is still awaiting \$61 from her insurance company for that office visit. Over the last five months, 22 bills from Dr. Williams have languished in claims processing centers.
 - "Insurers, Doctors Struggle with Texas Payment Law," J.C. Conklin, *The Dallas Morning News*, November 6, 2000 (www.accessmylibrary.com/coms2/summary_0286-6462073_ITM)
- Anger among doctors and hospitals toward slow-paying insurance companies is boiling over **across the nation**. The anger has politicized doctors' groups, inspired medical associations to press for tougher laws, spurred regulators to levy fines and, in Missouri sparked talk of a class-action lawsuit. Insurers, who have lobbied hard against more regulations, find themselves on the defensive. Spokesmen say health insurers are unfairly accused by medical activists. They insist the industry is paying claims faster as it embraces computers. For their part consumers are asked—perhaps unjustly—to take sides in the fracas, as they seek to vent

their own frustration with a complex system that can seem out of control. It can take months and even years for bills to get paid. And the consumer suffers.

o “Slow pace of medical insurance payments angers doctors, hospitals,” Paul Wenske and Julius A. Karash, *Kansas City Star*, May 20, 2000 (www.accessmylibrary.com/coms2/summary_0286-7265659_ITM)

- The **New York** State Insurance Department whipped out a stopwatch and a fine book to make health insurers pay claims on time. The department recently levied \$86,100 of fines to 18 health insurers, including Western New York's three big health plans, for dragging their feet with claims.

o “State Fines 18 Health Insurers For Not Paying Claims On Time,” News Business Reporter, *The Buffalo News*, February 12, 2000 (http://nl.newsbank.com/nl-search/we/Archives?p_product=BN&p_theme=bn&p_action=search&p_maxdocs=200&p_topdoc=1&p_text_direct-0=0EAF9C6EAF4BF96&p_field_direct-0=document_id&p_perpage=10&p_sort=YMD_date:D&s_trackval=GooglePM)

15. Insurers Deny Rural Americans Good Coverage

Insurance companies, with their limited provider networks, do not adequately serve the health care needs of people in rural areas, where providers are scarce to begin with. For example:

- The actuarial value of private health plans held by rural residents is lower than for urban residents, according to a study in the journal *Health Affairs*. Among privately insured people with health care spending in 2001 or 2002, 17 percent of rural residents spent more than \$1,000 out of pocket during the year, compared with 13 percent of urban residents. While urban residents were responsible for 32 percent of their total costs, rural residents covered 39 percent of their total health care costs. Rural-urban differences in out-of-pocket spending were not attributable to differences in the number of office-based visits or hospital inpatient visits and days. While urban residents requiring emergency care paid, on average, about 14 percent of their total emergency room costs out of pocket, rural residents paid 21 percent. For prescription drugs, use and costs were slightly higher for rural residents than those in urban areas.

Despite having private coverage, those who use medical services pay a sizable portion of their own health care costs, particularly rural residents. One out of eight rural residents is underinsured (12 percent), compared to 6 percent of urban residents. The odds of being underinsured remained 70 percent higher for rural residents than for urban residents.

- “Out-Of-Pocket Health Spending And The Rural Underinsured,” Erika C. Ziller, Andrew F. Coburn and Anush E. Yousefian, *Health Affairs*, November/December 2006 (<http://content.healthaffairs.org/cgi/content/abstract/25/6/1688>)

- Two months after the launch of the biggest preferred provider organization in **Georgia**, some rural areas are complaining about a shortage of physicians in the network. The Department of Community Health said this week that it's aware of the problem with the PPO, which serves more than 250,000 state employees, schoolteachers, dependents and retirees. Many physicians feel shut off from patients who are State Health Benefit Plan members. "We've been locked out," said Anne Thompson of the Southeastern Healthcare Alliance, representing a group of 60 physicians in rural North Georgia.

- “Rural Georgia Area Complains of Doctor Dearth under New Insurance Plan,” Andy Miller, *Atlanta Journal-Constitution*, September 9, 2000 (www.accessmylibrary.com/coms2/summary_0286-6489109_ITM)

Waiting to Be Saved By Medicare

Michelle Ippolito of Fallon, Nev., said private health insurance doesn't work well in rural areas:

"I'm a self-employed person in rural Nevada. Eight years ago I had a choice of two health insurance companies. The one I chose was bought out by Blue Cross a couple years back, which is now the only choice for self-employed people in rural counties in Nevada. My premium has gone up from \$100 a month in 2000 to \$240 a month today—that's for a policy with a \$2,000 deductible. The first two visits to the doctor each year I pay a \$35 co-pay. Any additional visits in a year, I pay the entire amount. And Blue Cross decides whether or not the visit and any lab fees, x-rays, etc. count towards the deductible. I can spend a fortune on health care and never reach the deductible!

All the talk of 'lowering' premiums by paying billions to insurance companies in subsidies makes me sick (no pun intended)! I wouldn't mind the \$240 a month if I got anything in return for it. Right now I am waiting to be old enough for Medicare to afford the surgery my doctor says I need, as I know with my current policy it will cost more than I can afford."

- In recent years, insurance premiums have soared in rural areas, forcing families to do without coverage.

- “Insurance crisis hangs over rural areas As premiums soar, small-group plans force families to do without coverage,” *The Gazette*, May 6, 2001 (http://nl.newsbank.com/nl-search/we/Archives?p_product=NewsLibrary&p_multi=CSGB&d_place=CSGB&p_theme=newslibrary2&p_action=search&p_maxdocs=200&p_topdoc=1&p_text_direct-0=0F34A99F9111891C&p_field_direct-0=document_id&p_perpage=10&p_sort=YMD_date:D&s_trackval=GooglePM)

16. Insurers Oppose Steps to Create Health Security

Insurance companies do not provide us with financial security. Too many insured people are going bankrupt when a family member faces a serious medical condition. Too many insured people go without needed care. Too many insured people fear a serious illness will destroy their financial future. For example:

- Heeding complaints from policyholders and consumer advocates, **California** state regulators intensified their investigation into whether recent rate hikes by Blue Cross of California helped finance the company's sale to an out-of-state health insurer in a \$21-billion deal. To win approval from state regulators, the combined company, now known as WellPoint Inc., pledged that 7.6 million California Blue Cross policyholders wouldn't be saddled with the estimated \$4 billion in expenses stemming from the deal—including financing and legal costs and severance pay for retiring executives. Consumer activists, citing anecdotal evidence gathered from policyholders, testified that some Blue Cross customers were being hit with rate increases of 20 to 40 percent on individual and family coverage, much larger increases than were seen in the past.

Premiums Skyrocket After a Fall

Elizabeth B. of Polson, Mont., said her family can't afford to keep health insurance.

"After years of paying high premiums with huge deductibles to Blue Cross Blue Shield of Montana and never really using the insurance, my husband broke his wrist in a fall. Even with the \$5,000 out-of-pocket we had to pay, there was about \$6,000 to be covered by the insurance, which they did. But several months later our premiums went up 43 percent! That made our insurance unaffordable. Now we carry catastrophic insurance with a \$10,000 deductible for each of us and pray that nothing happens to us."

- "Regulators Accelerate Probe of Hikes in Blue Cross Premiums," *Los Angeles Times*, Marc Lifsher, May 14, 2005 (<http://articles.latimes.com/2005/may/14/business/ft-wellpoint14>)
- Philadelphia organizers protested a request from Independence Blue Cross of **Pennsylvania** to increase health insurance premiums 20 to 58 percent for some plans purchased directly by individuals and families. In one plan, the monthly premium for a family with parents in their 30s would rise from \$1,069.15 to \$1,634, a 52.8 percent increase, according to the company's filings with the Pennsylvania Department of Insurance.
 - "Protest over Blue Cross premium increase," Jane M. Von Bergen, *Philadelphia Inquirer*, May 22, 2009 (www.philly.com/inquirer/business/20090522_Protest_over_Blue_Cross_premium_increase.html)
- Blue Cross and Blue Shield of **Texas**, a subsidiary of Health Care Service Corp., on June 13, 2008, was fined \$250,000 and required to set up a \$3.9 million restitution fund by the Texas insurance commissioner. The company failed to make non-preferred benefits reasonably available to its customers and failed to maintain an accurate listing of its preferred providers.
 - "Restitution due some Blue Cross and Blue Shield of Texas customers," Terrence Stutz, *Dallas Morning News*, August 9, 2008 (www.dentonrc.com/sharedcontent/dws/news/texasouthwest/stories/DN-insurefine_09tex.ART.State.Edition1.4da8c4b.html)
- United Healthcare, a subsidiary of UnitedHealth Group Inc., was ordered to pay the state of **Ohio** \$250,000 for telling 176,000 customers they would have to find new doctors or pay higher out-of-network prices. An investigation by the Ohio Department of Insurance found that the insurer panicked customers while negotiating with OhioHealth, central Ohio's largest

hospital system. Weeks before the three-year contract was signed, United Healthcare sent the letters to customers, incorrectly warning many of them that their doctors would no longer be part of the company's network. Patients swamped their doctors' offices with phone calls.

- "Letters will cost UnitedHealthcare \$250,000 fine," Suzanne Hoholik, *The Columbus Dispatch*, July 28, 2008
(www.columbusdispatch.com/live/content/local_news/stories/2008/07/28/uhc_settlement.html?sid=101)
- Community Insurance Company, a subsidiary of WellPoint Inc.'s Anthem Blue Cross and Blue Shield, agreed with the **Ohio** insurance regulators that the insurer's on-line provider directory for mental health providers in Hamilton County was inaccurate and misleading. The state investigated a complaint that the company was misrepresenting its provider network by identifying providers as "in network" when the providers were unreachable, not in the company's network or not accepting new patients.
 - "Anthem Blue Cross and Blue Shield's Community Insurance Company Signs Consent Order Agreeing to Inaccurate On-line Provider Directory," Ohio Department of Insurance, Press Release, May 27, 2008
(www.ohioinsurance.gov/Newsroom/scripts/Release.asp?ReleaseID=5483)
- The Office of the Insurance Commissioner in **Washington** ordered United Healthcare, a subsidiary of UnitedHealth Group Inc., to pay a \$59,500 fine following an agency investigation into the company's use of unapproved contracts to add chiropractors to its provider network. The investigation found the company continued to use provider agreements that contained an illegal retroactive-denial provision after it had been notified it was violating consumer protection regulations.
 - "United Healthcare fined in Washington," *Chiropractic Economics*, February 2007
(www.chiroeco.com/news/2007/February/United.php)
- A **California** state report found that arbitration procedures used by most health plans to resolve disputes with consumers are deeply flawed. Along with being costly for patients, arbitration is unfairly tilted in favor of health plans, according to the report issued by the California Research Bureau, the Legislature's research arm. More than 18 million people, constituting about 80 percent of managed-care enrollees in California are in health plans requiring that coverage disputes be resolved by arbitration instead of lawsuits. These provisions are often included without the patient's knowledge, the report said. The state also found that health plans may not be complying with legal requirements to notify the state of arbitration cases.
 - "HMO dispute setup flawed, report finds," Tony Fong, *The San Diego Union-Tribune*, January 12, 2001
(www.consumerwatchdog.org/patients/articles/?storyId=14721)
- Fed up with poor claims-handling practices, **Arizona** insurance regulators have imposed fines on one of the state's largest insurers. The penalties totaling \$61,000 came after state examiners found a series of instances where Tucson-based Intergroup Prepaid Health Services of Arizona had not responded within legally required time limits to appeals and grievances.
 - "HMO, 2nd insurer fined over claims handling," , September 9, 2000 (http://nl.newsbank.com/nl-search/we/Archives?p_product=ADSB&s_site=azstarnet&f_site=azstarnet&f_sitenam=Arizona+Daily+Star%2C+The+%28AZ%29&p_multi=ADSB&p_theme=gannett&p_action=search&p_maxdocs=200&p_topdoc=1&p_text_direct-0=0EACE687F9495A77&p_field_direct-0=document_id&p_perpage=10&p_sort=YMD_date:D&s_trackval=GooglePM)
- "That didn't take long. Less than two weeks have passed since much of the medical-industrial complex made a big show of working with President Obama on health care reform

— and the double-crossing is already well under way. Indeed, it’s now clear that even as they met with the president, pretending to be cooperative, insurers were gearing up to play the same destructive role they did the last time health reform was on the agenda... Blue Cross Blue Shield of **North Carolina** was preparing to run a series of ads attacking the public option. ...Just a week after the White House photo-op, The Washington Post reported that Blue Cross Blue Shield of North Carolina was preparing to run a series of ads attacking the public option. The planning for this ad campaign must have begun quite some time ago. The Post has the storyboards for the ads, and they read just like the infamous Harry and Louise ads that helped kill health care reform in 1993. Troubled Americans are shown being denied their choice of doctor, or forced to wait months for appointments, by faceless government bureaucrats. It’s a scary image that might make some sense if private health insurance — which these days comes primarily via HMOs — offered all of us free choice of doctors, with no wait for medical procedures. But my health plan isn’t like that. Is yours?”

- o “Blue Double Cross,” Paul Krugman, *New York Times*, May 22, 2009 (www.nytimes.com/2009/05/22/opinion/22krugman.html?_r=1)

Health Insurance Company Abuses

Index of States

Arizona..... 10, 23, 25, 27, 30, 37
California..... 4, 6-7, 9, 12-17, 19, 21-22, 25-26, 30-31, 36, 37
Colorado..... 25
Connecticut..... 7, 10, 14
Delaware..... 17
Florida..... 19, 25
Georgia..... 5, 27, 30-31, 34
Illinois..... 12
Indiana..... 8, 23, 31-32
Kansas..... 5
Kentucky..... 12, 20
Massachusetts..... 5, 28-29
Minnesota..... 23, 24
Missouri..... 12
Montana..... 24, 36
Nebraska..... 7, 9, 13
Nevada..... 34
New Jersey..... 4, 8
New York..... 4, 6, 10, 15, 17, 19-21, 25, 29, 31-33
North Carolina..... 19, 21, 26, 29, 30-31, 37-38
Ohio..... 12-13, 25, 31-32, 36-37
Oregon..... 7-8
Pennsylvania..... 4, 19, 36
Rhode Island..... 23
South Carolina..... 7
Texas..... 5, 13, 27, 30, 32, 36
Utah..... 14, 25
Virginia..... 8-9, 13
Washington..... 8, 17, 23, 25, 37

HEALTH CARE
FOR AMERICA **NOW!**

www.healthcareforamericanow.org