

NEWS RELEASE

August 7, 2007

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Regulators Investigate Patient Complaints of Blue Cross Rate Increases, Denials of Care That Violate 2004 Merger Deal:

Group Uncovers \$6.5 billion in Out-of-State Profit Transfers

Santa Monica, CA -- At a public meeting today in Los Angeles, Blue Cross patients facing steep rate increases and others whose doctor-recommended care has been canceled or refused joined consumer advocates to call for penalties against the company and broad-based health care reform.

The public meeting was organized by state regulators in response to complaints that Blue Cross violated a patient protection agreement, advocated by the Foundation for Taxpayer and Consumer Rights' (FTCR) and adopted as a condition of its 2004 merger with Anthem. The merger resulted in the formation of the nation's largest health insurer.

FTCR released today a new analysis that shows that up to \$6.5 billion in California insurance premiums were illegally transferred to Blue Cross' out-of-state parent company in violation of the 2004 merger agreement (including \$950 million in the first three months of 2007). [Click here to download FTCR's comments.](http://www.consumerwatchdog.org/resources/FTCRcomments.pdf) (<http://www.consumerwatchdog.org/resources/FTCRcomments.pdf>)

FTCR said that Blue Cross had broken its agreement with regulators not to charge patients for \$4.2 billion in merger financing costs and up to \$600 million in bonuses and stock options to top executives.

"We feared that Californians would ultimately pay for the merger through either increased rates or reductions in coverage. Both have come to pass. Blue Cross should not be allowed to continue to double cross patients and profit by breaking the law and refusing to honor the merger agreement," said Jerry Flanagan of FTCR. "At a time when 6.5 million Californians cannot afford coverage and millions more are underinsured, Blue Cross cannot be allowed to treat California like its ATM."

Blue Cross patient complaints collected by FTCR since the merger have ranged from denials of medically necessary care that resulted in the death of at least one patient to double-digit rate increases and a \$2 charge to enrollees for each mailed bill if they refuse to allow premium payments to be automatically deducted from their bank accounts.

FTCR called for regulators to pursue injunctions against Blue Cross to bar the illegal practices, because "overly aggressive underwriting practices and refusals to pay medical bills in conjunction with illegal cancellations of coverage produce profits that greatly exceed the anemic financial penalties issued by [regulators]." In addition, FTCR said financial oversight of Blue Cross should be continued indefinitely.

Blue Cross has contributed \$1.75 million to the governor and legislature since 2001 -- more than any other health insurer -- to block legislative health care reforms. Blue Cross recently vowed to spend another \$2 million to oppose reform attempts and led a successful effort to bury legislation that would have required health insurers to get approval for rate increases (AB 1554).

Key FTCR Findings of Merger Agreement Violations:

1. \$6.5 billion out-of-state transfer. Between 2004 and 2006, Blue Cross has made monetary transfers to affiliated companies in the form of dividends and so-called "management and service agreements" that exceed the amounts allowed by the merger agreement by up to \$6.5 billion. Such transfers may be laundering profits that exceed the legal limit established in the merger agreement, in the form of purported payment for services.

In written comments submitted to regulators, FTCR wrote that regulators: "[C]annot accept the transfers for 'management agreements and service contracts' at face value because without scrutiny, billions in illegal transfers could be included in payment for purported services. In fact, the financial incentive is precisely for the out-of-state affiliates to overcharge for services, and for BCC to willingly overpay, in order to transfer profit amounts that exceed the allowed limit.

What BCC is doing is no different from a public official steering public contracts to himself without competitive bidding. ... The overwhelming suspicion in such a case is that it is pure self-dealing, and no bargain to the public."

2. \$950 million First Quarter '07 Dividend: Independent auditors must review a \$950 million dividend BCC transferred to its out-of-state parent company in the first three months of this year. Per the merger agreement, that payment should not have exceeded \$141 million.

3. Bare-Bones Coverage: Since 2004, BCC has dramatically increased the number of limited benefit bare-bones policies in California -- a violation of the merger agreement that Blue Cross would not change its methodologies for determining products and benefit designs. As result, Californians pay more for less coverage and are not adequately protected when they get sick.

4. 'Pre-existing' Condition limitations Denials of Care: Huge out-of-state profit transfers have been funded by anti-consumer practices that have escalated in the years since the merger -- a violation of the merger agreement that Blue Cross would not changes its business practices. Internal Blue Cross underwriting documents revised one month prior to the merger approval

show that Blue Cross now regularly refuses to sell coverage at any price to people with minor health conditions like: Acne, Arthritis and Asthma. [Click here for more on the internal Blue Cross documents.](#)

5. Illegal policy terminations: Overwhelming evidence demonstrates a routine and flagrant violation of Health and Safety Code § 1389.3 barring insurance companies from terminating policies unless patients are shown to have made intentional misrepresentations of their health conditions on enrollment applications. Such practices violate provisions of the merger agreement that Blue Cross would not terminate policies except for instances of fraud.

Click here to download the 2004 Blue Cross/Anthem merger agreement.
(<http://www.consumerwatchdog.org/resources/BCCundertakings.pdf>)

Read about FTCR's work to hold Blue Cross accountable to its merger promises..
<http://www.consumerwatchdog.org/search/?string=%22blue+cross%22+merger&pageOp=Search>

August 8, 2007 Los Angeles Times

Blue Cross undergoes examination

The health plan comes under fire during a state regulatory hearing. The company says members are well served.

By Lisa Girion, Los Angeles Times Staff Writer

When an Indiana company bought Blue Cross of California in November 2003, it promised to maintain and improve the services and benefits of the state's largest health insurer.

Nearly three years later, state regulators say they have been besieged by complaints that patients are paying more and doctors are about to be paid less. Regulators held an unusual public hearing Tuesday in downtown Los Angeles to find out why.

Executives and supporters of Blue Cross were on hand to say the company is committed to California and that its policies represent a good deal for members.

Blue Cross said it only made sense that it would receive the most complaints because of its position as the state's No. 1 healthcare plan. The company said that on the whole its members were well served.

But the dominant message was just the opposite from a standing-room-only crowd of more than 200 patients, physicians and hospital operators at the daylong hearing.

"Something must be done now by the department," said Janet Stephens, a disabled nurse with a

bladder condition who has watched her benefits decline while her Blue Cross premium has steadily risen in recent years to \$569 a month.

Protesters carrying signs reading "Blue Cross makes us sick" picketed outside the hearing room before the meeting began. They said the health plan provided an example of why healthcare reform was needed.

"Blue Cross promised to be a good citizen," said Anthony Wright, executive director of HealthAccess California, a consumer group based in Sacramento. "But right now it's clear they need to be put on probation."

Cindy Ehnes, director of the state Department of Managed Health Care, called the hearing to help the agency evaluate how well Blue Cross has served Californians since it was purchased by Indianapolis-based WellPoint Inc. nearly three years ago. The department said it had received more than 4,100 calls and complaints regarding Blue Cross since the merger.

Ehnes said in an interview that the department would use the testimony to help decide whether the health plan lived up to the promises it made to win state approval for the November 2004 acquisition. She said a decision should be forthcoming within three months.

The department listed some of its concerns, including a \$950-million dividend WellPoint took from Blue Cross of California this year. That was almost twice the amount it took in each of the previous two years, the department said.

"The dividend is significant because it is extracting large amounts of money at the same time it is saying the increasing costs of healthcare require premium increases and benefit reductions," Ehnes said. "That's the concern."

Blue Cross of California's top executive attended the hearing to state the insurer's case.

President Brian Sassi told the regulatory panel that the health plan was striving to bring innovative insurance packages to California members while balancing their desire for affordable coverage amid soaring medical costs.

Perhaps one of the best measures of its success, he said, is that membership in Blue Cross of California and its affiliate health plan, BC Life & Health, is up 42% since 2000 to 8.3 million people.

Sassi said that the 2007 dividend was not bounded by the merger agreement, was the result of earnings accumulated over several years and was in line with those of other health plans.

Several other witnesses also testified in favor of Blue Cross. The California Assn. of Realtors, for instance, sent representatives to praise Blue Cross for underwriting its association health plan after competitor Blue Shield of California dropped it this year.

And Linda Lockwood gave Blue Cross credit for getting the proper care for her 10-year-old grandson when he became seriously ill. "We would like to say, 'Thank you,'" said the Southern California woman, who brought her grandson to the hearing.

But a parade of others, including several hemophiliacs and the father of a severely disabled boy, said Blue Cross had raised premiums, had denied treatments their doctors said were medically necessary or had changed benefits in a way they feared would compromise their health.

Several doctors complained about pending cuts in the reimbursements Blue Cross pays for services, saying the changes may force them to relocate their practices outside California.

"My concern is the outrageous profits coming at the expense of doctors and ultimately their patients," said Harriett Ringold, who manages her husband's South Bay endocrinology practice.

Ringold and others said Blue Cross told them the new rates were nonnegotiable.

Not so, said Blue Cross.

In fact, in response to the complaints, Blue Cross delayed the imposition of the new fees by three weeks to Aug. 30 and dropped its plan to cut reimbursements for newborn baby visits, as well as mammography and colonoscopy examinations. But the rest of the fee schedule, including reimbursement rates for hundreds of procedures, will take effect as planned, Blue Cross said.

"If physicians complain, we will look at" the fees, said Jeff Kamil, Blue Cross' medical director. "It's not like we're deaf-eared to what physicians think."

The Foundation for Consumer and Taxpayer Rights said it conducted an analysis of money Blue Cross has sent out of state to WellPoint and its affiliated companies since the acquisition, and the latest dividend was only the tip of the iceberg. The Santa Monica-based group, a frequent critic of the insurance industry, urged regulators to investigate as much as \$6.5 billion in transfers from Blue Cross to WellPoint and its affiliates out of state.

Shannon Troughton, a WellPoint spokeswoman, said the company had insufficient information about the group's analysis to comment but said she believed it was inaccurate.

Ehnes declined to detail what measures the Department of Managed Health Care could take if it determined Blue Cross was out of line. But her department issues Blue Cross' license to sell coverage in California, and it has the power to levy fines and take other actions.

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Original source: <http://www.latimes.com/business/la-fi-bluecross8aug08,1,1651170.story?ctrack=1&cset=true>

Jul 25, 2007 NEW YORK (Reuters) –

UPDATE: 3-WellPoint second-quarter profit rises 11 percent

(Recasts; adds comments, shares, details, byline) By Lewis Krauskopf

WellPoint Inc. (WLP.N: [Quote](#), [Profile](#), [Research](#)) posted an 11 percent rise in quarterly profit on Wednesday as the largest U.S. health insurer by enrollment saw a boost from net investment income, but results failed to excite investors and shares fell more than 3 percent.

WellPoint, whose results matched Wall Street's projections, also cut its forecasts for health plan membership and revenue after it said second-quarter enrollment fell from the first quarter amid declines for its national accounts business.

"There's nothing overly negative, but there's nothing overly positive either," Stifel Nicolaus analyst Thomas Carroll said. "There's no major catalyst to jump into the shares right now."

WellPoint heartened many analysts by spending less than they expected on medical costs as a percentage of premiums.

Rival UnitedHealth Group Inc. (UNH.N: [Quote](#), [Profile](#), [Research](#)) disappointed the market last week when it reported a key medical cost measure worsened from the prior quarter.

Investors are wary that health insurers will be forced to lower their pricing to secure membership growth as competition among plans heats up.

WellPoint executives repeatedly said on a conference call with analysts that they remained disciplined with pricing.

"We do not chase business that we believe is priced below our profitability targets," said Chief Financial Officer Wayne DeVeydt on the call.

Net income rose to \$835.2 million, or \$1.35 per share, from \$751.2 million, or \$1.17 per share, a year earlier. The earnings results matched analysts' average forecast, according to Reuters Estimates.

Revenue rose 7.7 percent to \$15.3 billion.

"It was a fine quarter, with no apparent issues, but the lack of any recent upside surprises will likely make it hard to argue that WellPoint deserves to trade at an appreciable premium to the rest of the group," CIBC analyst Carl McDonald said in a research note.

NEW LEADERSHIP

WellPoint, which operates many Blue Cross Blue Shield plans, is also looking to reassure investors about its direction after replacing its chief executive and chief financial officer in recent months.

Wednesday marked the debut for CEO Angela Braly and DeVeydt to lead the earnings call with analysts.

Braly assumed the CEO post from Larry Glasscock in June. DeVeydt in May replaced David Colby, who was widely respected on Wall Street but was ousted for unspecified violations of WellPoint's code of conduct.

Braly and DeVeydt are "going to have to earn back the reputation that Larry Glasscock and Dave Colby had, but I thought they did a fine job," Carroll said.

Health plan membership at the Indianapolis-based company rose by 604,000 from a year ago to 34.8 million.

However, membership fell by 108,000 members from the first quarter, hurt by greater-than-expected declines in the company's national accounts business. WellPoint cited employee reductions in various industries, including the automobile, home building and mortgage sectors.

The company's benefit expense ratio -- the percentage of premium dollars spent on medical costs -- worsened to 81.8 percent from 81.2 percent a year earlier. But the ratio, which is considered a key measure of profitability, improved from the 83.1 percent the company had reported for the first quarter.

Improvement in the company's business serving employers was countered by continued increases in medical costs in its Medicaid plans serving low-income Americans, particularly in California and Connecticut. WellPoint is the largest U.S. provider of Medicaid plans.

Net investment income rose 16 percent to \$253.4 million. WellPoint's sales, general and administrative expenses improved to 15.1 percent of revenue from 15.7 percent a year ago.

WellPoint forecast full-year earnings of \$5.55 per share, also in line with Wall Street's target.

The company lowered its year-end medical enrollment target to 35.1 million from 35.5 million. It also cut its full-year operating revenue target to about \$60.5 billion from its earlier projection of about \$61.1 billion.

WellPoint shares fell \$2.95, or 3.6 percent, to \$79.22 in morning trading on the New York Stock Exchange. The shares have risen about 1 percent in 2007, underperforming a roughly 3 percent rise for the S&P Managed Health Care index (.GSPHMO: [Quote](#), [Profile](#), [Research](#)).

<http://www.reuters.com/article/marketsNews/idUKN2529929620070725?rpc=44>

08/1/2007. Southern California Physician : [Los Angeles County Medical Association](#)

LACMA President's Letter: **Strengthen Your Contracting Process**

By [David Aizuss, MD](#)

Physicians must individually decide at what point contracting ceases to make sense.

By now most Los Angeles County Medical Association members should be aware of the controversy regarding Blue Cross of California's business practices.

In June, the company released a new fee schedule impacting contracted physicians in multiple ways. First, a variety of services saw minor increases or decreases. However, a large group of physician services, particularly procedural services performed by both primary care physicians and surgical specialists, have received cuts of up to 30 percent or more.

In addition, the state of California has charged that Blue Cross has channeled funds to its parent corporation in Indiana in vast amounts not permitted in the WellPoint-Anthem merger agreement. As a result, a special hearing in Los Angeles was scheduled for July 19, at which the California Medical Association and LACMA intended to testify. However, the hearing was delayed until this month.

Even so, LACMA physician leaders have been communicating with Blue Cross individually to

express our anger and dismay at the extent of the fee schedule changes and the lack of input contracted physicians had about these changes. No methodology for determining these cuts has been communicated. The capricious actions appear to be an effort to increase Blue Cross profit margins.

Due to the antitrust restrictions on the freedom with which physicians can negotiate with insurance companies and the discussions that we can have with each other, LACMA cannot and will not urge physicians to take any concerted action as a group with respect to the latest fee schedule alterations. However, every physician must be cognizant of his practice overhead and margin to ensure practice survival while making a reasonable income given the long years of training, steep education loans, and return on investment of time and energy. Physicians must individually decide at what point contracting ceases to make financial or ethical sense to their practices and patients. Too often I hear physicians voice the worry that if they drop bad contracts, they will go out of business or suffer substantial drops in income.

Interestingly, experience has taught physicians otherwise. I personally know an increasing number of colleagues who have dropped contracts that they believe provide inadequate compensation. None has seen more than a transitory drop in income. These same physicians are happy with their choices and the knowledge that their patients are choosing to see them because of their reputations, relationships and skill--not because they found their name in a book and gave a discount. Further, the success of concierge practices also means that patients are choosing to ignore insurance contracts and pay a substantial amount of money for the privilege of more personal, more time-intensive care.

Dropping contracts is not simple. It is a difficult business decision. In some partnerships, the busier physicians may seek to drop unsatisfactory contracts while the less busy physicians object to such a strategy since they fear loss of overflow from the busy physicians or loss of continuity of care with patients. In other situations, physicians are not educated about what their contracts contain, how to cancel a contract or even whether it is possible to negotiate a contract.

In all circumstances, it behooves each of us to express our displeasure individually to Blue Cross and other insurance companies that arbitrarily impose contract changes. Additionally, all physicians should communicate their concerns to the California Department of Managed Health Care and their elected representatives.

Our patients are our most potent allies. On a daily basis, I discuss with my patients where their healthcare premium is going. The patients are told that their insurance rates are going up due to increased healthcare costs. As we know, those costs are NOT due to increased physician reimbursement--and I make that very clear. I tell them about the large percentage of the premium dollar that goes to corporate profits. I tell them about the outlandish retirement packages and buyouts of health insurance executives. And I explain that physician reimbursement is falling. Then, I ask my patients to communicate their concerns to their state and federal elected officials.

We must get the message out that physicians can no longer bear cuts when the cost of everything from labor to rent and supplies is increasing. At some point, each of us must individually object to the insurance monopoly and turn our back on unacceptable contractual relationships.

(By publishing this article, neither LACMA nor the author are in any way suggesting that physicians terminate their managed care contracts or passing on a recommendation as to whether a contract is good or bad. Because of antitrust laws, independently competing physicians should not collectively decide whether to join or remain with a plan. Such an activity would be considered a group boycott in violation of antitrust laws).

July 17, 2007 :

CMA Statement on Blue Cross of California and Postponement of DMHC hearing
The California Medical Association issued the following statement by CMA President Anmol S. Mahal today:

Today it was announced that the Department of Managed Health care will postpone its public hearing on the status of Blue Cross of California's compliance with the undertakings provisions related to the 2004 merger with Anthem Health Care.

The postponement is the cause of extreme concern to California's physician community for a variety of reasons. It is our hope and expectation that DMHC will be vigilant and forceful in the demands required of Blue Cross in meeting its regulatory obligations. DMHC should not be deterred by the legal threats of a bad actor seeking to renege on its legal requirements. Blue Cross has partaken in a number of egregious violations related to its legal commitments. These violations are very harmful to patients and their physicians. Since the merger, there has been a sharp increase in payment delays. Spending on medical care and treatment has dropped below pre-merger levels, and there is even less administrative capacity to meet the legal obligations under the Knox-Keene Act.

There is clearly a history of bad-faith actions on the part of Blue Cross that make this insurance company's motives suspect. It is clear that Blue Cross will continue any and all efforts to delay action by the DMHC in order to protect profits at the expense of consumers. Blue Cross should be forthright and timely in dealing with the public and its customers, and not engage in legal maneuvering to hide its failures to comply with law

CMA President Anmol S. Mahal

Source: <http://www.cmanet.org/publicdoc.cfm/2/1/pressection2/398>

July 23, 2007: LA Times

Blue Cross cuts causing pain

Doctors object to lower reimbursements. The insurer says new rates will pay physicians at 'sustainable levels.'

By Lisa Girion, LA Times Staff Writer

Blue Cross of California's latest antidote to rising healthcare costs isn't going down very well with physicians.

The state's largest for-profit health plan is set to roll back its payments for about half the services and procedures provided by physicians next month.

And many of the 53,408 physicians in Blue Cross' preferred provider organization (PPO) networks say that's a prescription for disaster.

Doctors say the health plan imposed the new rates unilaterally. In most cases, they say, Blue Cross will get its way because it controls the lion's share of their patient base.

But other physicians say they've had it with Blue Cross. More than 300 of them have sent notices threatening to dump the insurer if the rates take effect as scheduled Aug. 6. Some say the new rates won't even cover the cost of supplies.

"I don't know how anybody can afford to stay in practice and accept Blue Cross rates," said Dr. Charles Fishman, a San Luis Obispo dermatologist who sent a letter telling Blue Cross he would drop its contract if his rates were not improved.

A spokeswoman for the insurer described the level of complaints over the new rates as routine, and she said the number of termination notices from physicians over the issue was negligible — less than 1% of the doctors in its PPO networks.

"We continue to have the largest physician network of all our competitors," said Shannon Troughton, a spokeswoman for Blue Cross' parent company, Indianapolis-based WellPoint Inc.

The rate dispute is the latest skirmish between physicians and Blue Cross since the insurer was purchased by the Indianapolis company formerly named Anthem nearly three years ago.

It is one of many complaints expected to be aired at a public hearing on Blue Cross set for Aug. 7 in Los Angeles.

Cindy Ehnes, director of the California Department of Managed Health Care, called the session to hear whether the insurer was living up to promises it made to win approval for the November 2004 deal that transformed the Indiana company into one of the nation's largest providers of health benefits.

Troughton said WellPoint had been a good corporate citizen since it took over California's Blue Cross. She said its growing enrollment was evidence that it was providing a service consumers valued.

She said the new reimbursement rates were intended to pay physicians at "sustainable levels." The insurer does not intend to pay physicians' less than their costs, but determining what those costs are is difficult, she said.

So, she said, the rates were largely based on cost and reimbursement data from other payers, particularly Medicare, the government's health insurance program for seniors.

Because of its unparalleled patient base and because of federal budget constraints, Medicare traditionally has paid far less than commercial insurers. Now, for many procedures, Blue Cross will pay less than Medicare, physicians say.

Troughton said the new rates include almost as many increases as decreases. Primary care physicians will tend to fare better than specialists under the new rates, she said.

This reflects an industrywide effort to counter an emerging shortage of primary care physicians

by raising the pay for these general and preventive care practitioners relative to specialists.

But even some primary care physicians say their practices will suffer under the new rates.

"If we make 10 or 15 cents on a vaccine, that's good ... and that's not counting our staff" time, said Dr. Ken Diamond, a Beverly Hills pediatrician. "I don't want to make a huge markup on vaccines because they are so important, but I have to be able to pay our nurses."

Diamond's partner, Dr. Ron Nagel, said he knows many people will find it difficult to sympathize with physicians who have traditionally been well compensated.

But, he said, the cuts were economically devastating, particularly for physicians who begin their careers with more than \$100,000 in educational loans to repay and whose overhead is constantly rising.

Like other physicians, Nagel said the rates for many of his services will be cut by a third or half. He is particularly outraged by what Blue Cross says it will pay him for a newborn hospital checkup.

The visit, which includes discussing lactation and other issues with the mother, is set to be reduced from \$51 to \$28.

"That is insulting," Nagel said.

But the pediatricians said they can't walk away from Blue Cross because it covers more than half their patients, and, in Beverly Hills, they figure there are plenty of other pediatricians willing to step in.

Blue Cross "won't renegotiate," Nagel said. "They will say, 'You take it or leave it.' "

In San Luis Obispo, Fishman said he was prepared to drop his Blue Cross contract if a better deal was not forthcoming from the insurer. But he said he would not turn away loyal patients.

Instead, he will ask Blue Cross patients who wish to continue seeing him to pay his fee up front. As a courtesy, his office will submit claims to Blue Cross on the patient's behalf. But the patients will have to absorb any difference between his fee and the reimbursement.

Dr. Daniel Lensink, an ophthalmic plastic surgeon in Redding, said Blue Cross was cutting his pay to remove a patch of skin cancer from an eyelid from \$231 to \$179.

He sent a letter threatening to drop out unless Blue Cross negotiated some of his rates. As the only specialist of his type between Sacramento and Eugene, Ore., he said he wouldn't turn away Blue Cross patients. But they may have to pay higher out-of-network co-payments for his services.

"Doctors feel like the bottom is falling out," said Lensink, the president of the region's medical society.

One Newport Beach oncology practice figures the new rates will result in a \$400,000 annual loss on the cost of treating their Blue Cross patients, who make up 40% of its cases.

As a result, Newport Cancer Care & Medical Associates sent letters to those patients explaining

that they would be expected to pay the difference between the reimbursement rate and the costs of their chemotherapy.

"We have to have you sign your life away in order to cover the cost of treatment if Blue Cross won't pay," said practice administrator Beau Donegan.

She said the group had no choice. At as much as \$80,000 per patient per course of treatment, the group spends an average of \$1.5-million on chemotherapy drugs a month. The group faces being cut off if it doesn't pay the suppliers within 30 days.

"If we're not getting reimbursed, we can't pay for the drugs for the other patients," Donegan said. "The pharmaceutical companies and the insurance companies are the ones who are truly the profit-takers, and we're caught in the middle. The patients and the physicians are caught in the middle."

Dr. Ralph Armstrong, an osteopathic obstetrician-gynecologist in Hollister, said the reimbursements for procedures he performs often are being slashed. Gall bladder removals and appendectomies, for instance, are set to be reduced 28%.

"If this is a good part of your practice and all of a sudden your rates are being decreased significantly, you might not be able to practice here any more," said Armstrong, who is president of the San Benito County Medical Society. "We have only three general surgeons in town. If we lost one of our general surgeons that would be devastating."

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(INFOBOX BELOW)

Healthcare hearing

Physician and consumer complaints about Blue Cross of California will be aired at a state hearing next month in Los Angeles.

The state Department of Managed Health Care's hearing is scheduled for Tuesday, Aug. 7, from 10 a.m. until 3 p.m. in the Carmel Room Auditorium at the Junipero Serra Building, 320 West 4th St., Los Angeles.

In addition to physicians' complaints, regulators are expected to take testimony from the public about premium increases, retroactive cancellation of individual coverage after a serious illness and the level of corporate profit, including a recent payment of \$950 million by Blue Cross of California to WellPoint Inc., its corporate parent.

For more information or to submit comments to state regulators, contact Denise Schmidt at (916) 322-2078 or send an e-mail to publiccomments@dmhc.ca.gov. You may also submit written

comments by mail to Department of Managed Health Care, 980 9th St., Suite 500, Sacramento, CA 95814.

— Lisa Girion

<http://www.latimes.com/business/la-fi-bluecross23jul23,0,4709642,full.story?coll=la-home-business>

July 17, 2007 LA Times

Blue Cross wins delay of hearing

Regulators reschedule a meeting on complaints after the insurer asks for a detailed agenda.

By Lisa Girion, LA Times Staff Writer

State regulators Monday postponed a hearing originally set for this week on complaints against Blue Cross of California, because its parent company has requested a more detailed agenda.

The hearing now is set for Aug. 7 in Los Angeles.

The state Department of Managed Health Care, which oversees HMOs, said last week that it had received more than 1,600 complaints from policyholders and doctors in less than three years against Blue Cross, the state's largest health insurer.

Department Director Cindy Ehnes called the meeting to air policyholders' complaints about premium increases, retroactive revocation of coverage after a serious illness or injury, and other problems. The hearing also was to be a forum for gathering more information on about 1,200 physician complaints, which are mostly pay disputes.

The department said the hearing also would help it determine how well Blue Cross is measuring up to the promises its parent, WellPoint Inc. of Indianapolis, made in 2004 to win regulatory approval for the deal that created WellPoint.

WellPoint spokeswoman Shannon Troughton said the original notice and agenda were not detailed enough to satisfy open-meeting laws aimed at giving the subjects, such as the company, the opportunity to fully address issues brought forward and allowing the public to participate.

"Apparently the department agreed with us," Troughton said.

"We look forward to the upcoming meeting so that we can provide information to the department about their concerns with our successful merger," she added.

July 11, 2007: LA Times

Complaints spark state hearing on Blue Cross

Regulators want to see whether the healthcare firm is adhering to an accord with California.

By Lisa Girion, LA Times Staff Writer

California has received more than 1,600 complaints from consumers, physicians and hospitals about Blue Cross of California since the state's largest health insurer was acquired by an Indiana firm in 2004, officials said Tuesday.

The state announced plans this week to hold a public hearing in Los Angeles on July 19 on how well Blue Cross has lived up to promises it made nearly three years ago as part of the \$21-billion acquisition.

The Department of Managed Health Care says it has received complaints from consumers about premium hikes and from physicians about delays and other problems collecting fees.

"We must have assurances that Blue Cross' No. 1 goal is to provide quality healthcare — not simply to increase its profitability," said Cindy Ehnes, director of the California Department of Managed Health Care.

State officials said they considered the level of complaints troubling but lacked comparable data from before the 2004 takeover of Blue Cross of California's parent, WellPoint Health Networks Inc., by Anthem Inc. The combined company was then called WellPoint Inc.

It is the latest sign that state regulators are stepping up scrutiny of insurers, particularly Blue Cross, a unit of Indianapolis-based WellPoint, which has more than 8 million customers in California.

WellPoint spokeswoman Shannon Troughton said the company would send representatives to the hearing.

"We value our relationship with the Department of Managed Health Care and we'll address any concerns or questions they may have," Troughton said in an e-mail.

The hearing notice is the second dose of bad news in two weeks for the company's California operations.

The Department of Insurance, another California regulator, last week issued a report of an investigation that found BC Life & Health, another WellPoint unit, had revoked 1,880 individual health insurance policies in California in 2004 and 2005, and a review of 83 sample cases cited more than half for alleged violations of fair claims handling laws.

The citations could lead to fines of as much as \$10,000 per infraction.

The 2004 deal was criticized at the time because it required an estimated \$3.4 billion in debt and because it bestowed payouts to WellPoint executives in California of as much as \$600 million.

The combination made the company one of the nation's largest and most profitable health insurers, with net income last year of \$3.1 billion on \$57 billion in revenue.

State regulators approved the deal on the conditions that WellPoint use no revenue from California policyholder premiums to finance the deal or for executive payouts and that healthcare would not be negatively affected. Those agreements expire at the end of November.

This summer, Blue Cross is imposing fee reductions on physicians at the same time it is sending letters to policyholders notifying them that their premiums are going up because of increasing medical expenses, said Karen Nikos, a spokeswoman for the California Medical Assn., the state's largest physician trade group.

"This is exactly what we said would happen," she said. "This is what happens when you only have a few insurance companies controlling all insurance. They do it because they can."

Regulators also are troubled by a \$950-million payment Blue Cross made this spring to WellPoint. The department is investigating whether the payment violates the state's terms for the acquisition.

"The Department of Managed Health Care has been turning up the heat on insurers that have been illegally canceling coverage and are profiting as a result," said Jerry Flanagan, a patient advocate with the Foundation for Consumer and Taxpayer Rights. "It's totally appropriate that they should have to explain their actions in a public hearing."

Flanagan said the department should look into all the fund transfers between Blue Cross in California and out-of-state WellPoint companies.

For example, he said, Blue Cross paid an out-of-state sister company \$1.3 billion last year for claims processing. It was earmarked in a regulatory filing as a medical care expense, which inflates the insurer's ratio of healthcare to overhead spending and profit taking, he said.

Other issues on the regulator's radar include Blue Cross' retroactive cancellation of sick patients.

In March, the department announced its intent to fine Blue Cross \$1 million after concluding that almost all of the cancellations its investigators examined violated state law.

The financial and healthcare problems for patients whose policies were rescinded have been highlighted in a series of articles in The Times.

The hearing comes amid various healthcare reform efforts in California that could affect the way insurers do business. Several of them stem from the belief that insurers are profiting at policyholders' expense.

One reform measure, Assembly Bill 1554, set to be heard by the state Senate Health Committee today, would require health insurers to justify rate increases as well as profits and transfers to out-of-state companies — something auto and home insurers already must do. The bill was approved by the Assembly.

A coalition of consumer and labor groups, including AARP and Consumers Union, also Tuesday launched sickofbluecross.com to combat the company's campaign against healthcare overhaul efforts, including Gov. Arnold Schwarzenegger's proposal to require insurers to sell coverage to anyone regardless of medical condition.

"We wanted to make sure there was a place where consumers could realize what Blue Cross' motives are in wanting to stop health reform," said Anthony Wright, executive director of Health Access California, one of the consumer advocacy groups involved in the effort.

Clearly it is Blue Cross' desire, he said, "to continue to be able to deny people coverage because of preexisting conditions and to spend less than 85% on healthcare rather than on profits."

The governor also has proposed mandating that health insurers spend at least 85% of revenue on healthcare as opposed to overhead and profit taking.

The department's hearing announcement posted on its website solicits testimony from the public on a host of issues.

WellPoint's Troughton said the department had "not provided us with a specific list of issues that will be covered during the hearing, so it would be premature to speculate on what those issues may be."

Troughton has said that health insurance remains a competitive industry and does not exhibit excessive profit margins.

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<http://www.latimes.com/business/careers/work/la-fi-insure11jul11,1,3284067,full.story?coll=la-headlines-business-careers&ctrack=2&cset=true>

July 3, 2007 : LA Times

Health insurer cited in policy cancellations

BC Life mishandled more than half the cases reviewed by the state. Critics say regulators have not done enough.

By Lisa Girion, LA Times Staff Writer

BC Life & Health revoked 1,880 individual health insurance policies in California in 2004 and 2005, and a state agency that examined a sampling says it found that more than half the cases it reviewed were improperly handled.

The Department of Insurance said it studied 83 sample cases and issued citations in 49 of them, alleging 67 violations of fair-claims handling laws.

In one case, the department contended that BC Life, a Blue Cross company, told a policyholder

in a letter that it rescinded coverage because of an undisclosed medical condition, even though the condition was clearly stated on the individual's application.

In another case, the department alleged that BC Life improperly rescinded a policy after miscalculating the period of time between treatment and the effective date of coverage. BC Life declined to reinstate coverage even after the department brought the error to its attention, according to a report issued by the agency.

When coverage is rescinded, it is as if the policy never existed, leaving the policyholder and healthcare providers to settle outstanding charges.

The 67 citations could lead to fines of as much as \$10,000 per sustained infraction, as well as follow-up examinations.

The report was posted on the department's website last week with little fanfare, even though it had been highly anticipated by consumer advocates and lawyers for policyholders who were suing BC Life and other insurers, challenging the rescissions as unfair and illegal.

The Department of Insurance launched an investigation last year when John Garamendi, now lieutenant governor, was the commissioner. The report marks one of the first occasions on which Insurance Commissioner Steve Poizner, who took office in January, has publicly weighed in on a health insurance issue.

"A rescission can be a financial death sentence when you're ill," Poizner said in an e-mail. "In my view, even one improper rescission is one too many. When it comes to rescissions, we are acutely aware that these are people's lives. They're not just numbers to us."

A series of articles in The Times over the last year exposed the common practice by insurers in California of canceling individual policies when patients submitted claims for serious illnesses. The practice does not apply to group policies.

A spokesman said that the department was looking at rescissions industrywide and that BC Life was one of several companies under the microscope. The others include Blue Shield, HealthNet, Cigna and Aetna.

Asked to comment on the report, a spokeswoman for Indianapolis-based WellPoint Inc., which owns BC Life, noted that the majority of the citations were for "technical violations of the claims-handling processes" and that "in nearly every case, the DOI concluded that the rescission was appropriate."

The Department of Insurance is the second California regulator to take on WellPoint, the state's largest insurer, over its practices in rescinding coverage. In March, the state Department of Managed Health Care, which regulates health maintenance organizations, hit sister company Blue Cross of California with a \$1-million fine after reviewing 90 rescissions and finding alleged violations of state law in every one.

Cindy Ehnes, director of the state managed care agency, said she was pleased to see the Department of Insurance applying fair-claims laws to rescissions. Health plans wield a great deal of power in setting up the way their policies work and in deciding what promises to make to policyholders, she said, and it is up to regulators to hold them to those promises.

"It is ultimately about fundamental fairness in the process that the health plan has every

opportunity to design in its favor," Ehnes said.

On the heels of the Department of Managed Health Care's probe, the Department of Insurance report is evidence that BC Life isn't playing fair, said Bryan Liang, a physician, lawyer and executive director of the Health Law Institute at the California Western School of Law in San Diego.

"We've got verification from another department doing its own investigation that this is happening consistently," Liang said. "Clearly, the system is broken.... Patients are getting harmed left and right, and nothing is getting done."

William Shernoff, a Claremont lawyer who represents policyholders suing BC Life, says the report shows BC Life' rescission process is deeply flawed.

"It's not a good report card," he said. "I would say it's a D-minus."

Others were critical of what they said was the report's focus on process rather than substance.

"It is sort of like giving a bank robber a speeding ticket for driving too fast in the getaway car," said Jerry Flanagan, a patient advocate with the Foundation for Consumer and Taxpayer Rights. "The real question is, what will they do next and are they looking at the underlying crime as opposed to a misdemeanor?"

Department officials said investigators had also examined BC Life's compliance with other laws, including those that govern rescissions. But Byron Tucker, a department spokesman, said a long-standing policy prohibited the agency from releasing the results of that part of the investigation. Only if formal legal action is taken can those findings be made public, Tucker said.

Doug Heller, executive director of the Foundation for Consumer and Taxpayer Rights, said that was ridiculous. "An agency whose responsibility is to be both transparent and to address the improprieties of the insurance industry should not be hiding behind some memo to keep a health insurer's dirty secrets behind closed doors," Heller said.

Scott Svonkin, a former insurance executive and chairman of the Los Angeles County Commission on Insurance, an advisory panel, said he was troubled that the Department of Insurance would end up giving BC Life a "slap on the hand." He called it a test for Poizner. "Will he step up and take action?" Svonkin said.

Department officials said it was wrong to draw conclusions about the agency or the commissioner at this stage of the investigation. Poizner said in the e-mail that the department was "dedicated to the comprehensive review and evaluation of insurer's decisions — especially policies and actions that negatively impact consumers."

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(INFOBOX BELOW)

What the review found

The California Department of Insurance issued 67 citations to BC Life & Health after a review of

83 rescissions carried out in 2004 and 2005. If sustained, each citation could lead to a fine of up to \$10,000. Among them are:

- Thirty-two citations for failing to promptly, fairly and equitably pay claims where liability was reasonably clear.
- Twenty-seven citations for failing to adopt and implement reasonable standards for the prompt investigation and processing of claims.
- Four citations for misrepresenting policy provisions to consumers.

The report can be viewed at <http://www20.insurance.ca.gov/epubacc/REPORT/98969.htm> .

The company's formal response can be viewed at <http://www20.insurance.ca.gov/epubacc/RESPONSE/99729.htm> .

Source: California Department of Insurance

NEWS RELEASE : The Foundation for Taxpayer and Consumer Rights (FTCR)

January 8, 2007

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Internal Documents Show Insurers Won't Sell Health Policies to Cops, Firefighters, Expectant Dads, Allergy & Acne Sufferers, etc.:

Schwarzenegger, Himself Uninsurable, Should Force CA Insurers To Sell To All Patients

Santa Monica, CA -- Firefighters, police officers, steel workers, expectant fathers, pregnant women and patients with asthma, acne, allergies, and toe nail fungus will not be sold health insurance policies in California, according to internal insurer underwriting guidelines made public today by the Foundation for Taxpayer and Consumer Rights (FTCR).

Under the insurer guidelines, Governor Schwarzenegger, who will announce his health insurance reform plan today in Sacramento, would be uninsurable because of his past heart valve replacement, recent leg surgery and past occupation as an athlete. FTCR said the documents show why Schwarzenegger's plan needs to force insurance companies to take all patients and must regulate the premiums charged.

"These documents show why Governor Schwarzenegger must demand that insurance companies sell policies to the uninsured if he wants to insure more Californians," said Jerry Flanagan, FTCR's Health Policy Director. "We now know why 1 in 5 Californians are uninsured, because insurers refuse to sell policies to people with pimples, allergies or a blacklisted occupation. Even the Governor himself would be uninsurable under the guidelines."

The guidelines also prevent Californians from going into business for themselves, because they cannot get insurance, said FTCR. Download underwriting documents for each company here:

* [PacifiCare](#)

* [Blue Cross](#)

* [Blue Shield](#)

* [Health Net](#)

The underwriting guidelines -- industry rules determining who will be allowed to buy coverage -- reveal that insurers deny applicants based on occupation, use of a wide range of common prescription drugs, minor health conditions or mere "symptoms" that have not been reported to a physician.

Some Uninsurable Occupations*:

Air Traffic Controllers

Athletes

Construction Workers

Firefighters

Migrant Workers

Police Officers

Public Utility Worker

War Correspondents

* Blue Shield, PacifiCare

Some Uninsurable Rx:

Allegra (allergies)

Advair (asthma)

Celebrex (arthritis)

Imitrex (migraines)

Lamisil (toe nail fungus)

Lipitor (cholesterol)

Nexium (heartburn)

Prevacid (ulcers)

Some Uninsurable "Conditions":

Acne

Asthma

Arthritis

ADD

Expectant father

Sickle Cell Anemia

Therapy/counseling

Or, any "symptoms" for which physician was not consulted

FTCR called on Schwarzenegger to:

- * Require insurers to take all buyers, regardless of preexisting conditions.
- * Require insurers to base premiums on broad characteristics such as age categories and regional healthcare costs -- not on a buyer's specific medical condition.
- * Regulate excessive health insurer profits and bloated overhead, just as auto premiums are regulated under Prop 103.
- * Ban health insurance policies that fail to set limits on what patients can pay.

For more information on FTCR's recommendations, see:

- * [FTCR's letter to Gov. Schwarzenegger](http://www.consumerwatchdog.org/healthcare/rp/7098.pdf) (<http://www.consumerwatchdog.org/healthcare/rp/7098.pdf>)
- * [Jamie Court & Judy Dugan's Op-Ed](http://www.consumerwatchdog.org/healthcare/co/?postId=7211) (<http://www.consumerwatchdog.org/healthcare/co/?postId=7211>)

Schwarzenegger, who has received nearly \$1 million in campaign contributions from insurers, has indicated he favors a plan that would require everyone to buy health insurance but has not mentioned long-overdue reforms of the insurance industry.

"How can Schwarzenegger require Californians to buy health coverage from insurers who have ultimate power to decide who to insure and can charge whatever they please?," said Judy Dugan, Research Director for FTCR.

Health insurers argue that the free market and minimal regulatory oversight gives them the ability to expand coverage. FTCR said the underwriting guidelines are undeniable proof of the hypocrisy of the health insurer's claim.

"Maximum flexibility means insurers can deny health insurance for any reason they choose," said Dugan.

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The Foundation for Taxpayer and Consumer Rights (FTCR) is the state's leading public interest advocacy organization. For more information visit us online at <http://www.ConsumerWatchdog.org> .

Source: <http://www.consumerwatchdog.org/healthcare/pr/?postId=7218>

