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# Patient-Doctor Alliances Can Prevent Rescission Abuse

From David A. Robinson, Esq. – December 6, 2007

Another storm appears to be brewing in California's health care horizon. According to recent court filings, pending administrative inquiries and industry gurus, major health insurance plans like Health Net and Blue Cross are denying scores of California residents benefits after they become pregnant or seriously ill. Specifically, the plans are accused of using software, "specialists" and, in the case of Health Net, employee compensation incentives, to weed out individuals accused of obtaining coverage by fraud, misrepresentation or non-disclosure on an application for enrollment or membership.

The plans say they do not have to pay, because they were fooled into accepting such individuals as premium paying members in their HMOs and PPOs. But who is fooling whom?

Before most individuals with health plan membership cards are admitted into hospitals or doctors' offices for non-emergency services, the hospitals and doctors have followed detailed steps laid out in their contracts with the plans to verify the prospective patient's eligibility. This entails telephoning or logging into the plans' benefits verification systems to obtain a "verification code." The code is said to guarantee eligibility. Once eligibility is guaranteed, the hospitals and doctors are contractually required to provide plan enrollees medically necessary services in the same manner and quality as those services are provided to other patients.

Every year, a significant number of people denied insurance benefits on the grounds of fraud or misrepresentation have already received substantial health care services. So what happens to the hospitals and doctors who provided those services? With increasing regularity, they are essentially told "tough luck" by the plans. They are also told to seek payment of, in some instances, tens of thousands of dollars against seriously ill individuals. Whereas the plans escape their duty to pay, the patients lose coverage many thought had been guaranteed and the hospitals and doctors bear the brunt of economic loss.

## A Question of Fairness

Is this fair? In defending the practice, the plans point to two factors: First, most claim the legal right to withhold payment if coverage is determined to have been obtained by misrepresentation. Second, as reportedly explained by Shannon Troughton, a spokeswoman for Wellpoint Inc., Blue Cross' parent company, under California law "rescission generally does

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not require a showing of intent to deceive or willful misrepresentation … All that is required for the misrepresentation to be intentional is that the true facts be known to the applicant."

Yet, as noted by one class action lawyer who recently filed suit against Blue Cross, patients "do not go to medical school and rarely know of or understand the information in their medical records."

In the same vein, earlier lawsuits accused both Blue Cross and Health Net of confusing and ambiguous medical history questionnaires to trick applicants into making mistakes that could later be used to cancel coverage.

So where does this practice leave California's struggling health care industry? By failing to investigate possible misrepresentations until after verifying, and thus "guaranteeing," their members' eligibility to receive services, health plans shift 100 percent of the risk of alleged patient misrepresentation to hospitals and doctors. In the meantime, while many hospitals struggle to control salaries and costs, last year WellPoint earned $3.1 billion in profit on reported revenue of $57 billion. So, again, who is fooling whom?

**Radical Reform**

The only way to avert a multi-front battle over this "take from the poor, give to the rich" practice is for health plans to radically reform the way they do business. Quite simply, a significant portion of the plans' underwriting effort appears to kick into high gear only after there has been detrimental reliance by plan members and health care providers.

Section 1389.3 of California's Knox-Keene health Care Service Plan Act of 1975 already forbids plans from engaging in so-called post-claims underwriting. Yet, according to findings of the Department of Managed Health Care released earlier this year, in 39 of 90 surveyed cases occurring between May 15, 2006 and July 7, 2006, Blue Cross violated Section 1389.3 by failing to "consistently complete pre-enrollment medical underwriting" and failing to "resolve all reasonable questions arising from the written information submitted on or with an application prior to issuing and individual enrollment contract."

In all 90 surveyed cases, the DMHC found that Blue Cross failed to "implement the express language of Section 1389.3, which requires 'a showing of willful misrepresentation' before … rescind[ing] and enrollee's coverage," and further failed to "gather sufficient information or conduct adequate analysis to support a showing of willful misrepresentation prior to rescinding coverage."

According to documents handed over to the DMHC after the Los Angeles Superior Court ordered their disclosure on Nov. 8, Health Net went further and based employee compensation, in part, on the rescission of individual health policies.

Per the DMHC, Health Net previously denied having such a compensation system in place.

Voluntary reform, however, appears unlikely. Various health care providers view the practice of post-claims underwriting as a prevalent and possibly on the rise. In the meantime, Blue Cross is disputing the DMHC's above-quoted administrative findings.

The de minimus $1 million fines recently imposed on the Blue Cross and Health Net by the DMHC afford inadequate relief to aggrieved hospitals, doctors or ousted individual plan members. Moreover, early efforts by health care providers to sue plans (principally in Arizona or Tennessee) for refusing to pay for services

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rendered after plan member eligibility had been verified have largely failed.

In short, until now there has been little in the law to encourage meaningful reform. To the contrary, a cottage industry of specialists has sprung up to help plans retroactively scrutinize the membership applications of individuals diagnosed with costly conditions. The DMHC found that Blue Cross monitors all submitted claims to detect the presence of diagnoses likely to indicate pre-existing conditions.

**Misplaced Litigation**

Although laudable, efforts by consumer rights advocates to attack the problem by filing individual and class action lawsuits on behalf of ousted individual plan members are unlikely to reverse this trend.

The difficulties of certifying a class action where the alleged class consists of a group of diversely situated individuals denied coverage on the basis of separate alleged factual misrepresentations might be impossible to overcome. On the other hand, attacking the problem piecemeal through a series of isolated and expensive consumer lawsuits is unlikely to provide the plans with adequate impetus to discontinue what amounts to a highly profitable practice.

A more logical approach might be for aggrieved hospitals and doctors' groups to band together in jointly suing major health plans accused of this practice on a variety of grounds, including, but not limited to: breach of contract; breach of the implied covenant of good faith and fair dealing; breach of contract based on possible assignments obtained from the cancelled policyholders; breach of contract as third-party beneficiaries; "unlawful, unfair or fraudulent business practices" in violation of business and Professions Code Section 17200; and quantum meruit and other common counts.

Support for a "good faith and fair dealing claim" might come from the fact that health care providers are barred from "direct billing" plan enrollees for services rendered, even if a plan unreasonably or illegally refuses to pay for such services.

The plans' previously noted argument that providers are free to pursue their money in separate collection actions against seriously ill individuals is, in addition to being impractical and callous, most likely contrary to law – further underscoring the Catch 22 created by the plans' post-claims underwriting.

Plans traditionally have defended against provider lawsuits by arguing that the DMCH has exclusive jurisdiction over the enforcement of Knox-Keene violations. During the past two years, however, various California appellate courts have rejected this defense. Providers are now recognized to have the right to seek injunctive relief under the UCL with respect to a plan's violation fo Health and Safety Code Section 1371 (requiring payment of uncontested claims no later than 30 working days after receipt, except for HMOs, which have 45 days to pay) and to seek compensatory damages under common law.

The only viable alternative to such a cooperative, multi-provider legal offensive would be for our state Legislature to enact a new law empowering aggrieved providers to enforce the operative Knox-Keene provisions via civil actions seeking compensatory and exemplary damages, together with the recovery of attorneys' fees.

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If such legislation were to go into effect, the practice of post-claims underwriting by health plans would most likely disappear overnight.

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