FOUL PLAY: Insurance Company Mistreatment
Top Ten Health Insurance Company Scandals

10. Giving bonuses to employees for canceling people's insurance contracts after they get sick or pregnant

According to the *Los Angeles Times*, California's Health Net "avoided paying $35.5 million in medical expenses by rescinding about 1,600 policies between 2000 and 2006." This dirty 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 isn't the only one ripping up people's policies. How many other companies around the country are pulling the same trick?

9. Redlining pregnant women to avoid covering them

"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's Illinois director of medical management. Five years later, a federal jury awarded $48 million in damages against the insurer and its parent company for discriminating against people with health conditions and pregnant women enrolled in the federal Medicaid program – discrimination that's still allowed in many states' private health insurance markets.

8. Sketchy stock-option deals and huge pay packages for executives

In 2006, UnitedHealth CEO William McGuire found himself in hot water with the Security and Exchange Commission over a stock options backdating scandal. Facing legal troubles – and questions from U.S. Senators – he forfeited $620 million in stock option and retirement compensation and resigned. But he still made away with stock options valued at $800 million and took home $530 million in compensation between 1991 and 2006.

But it's not just the giant corporation where execs rake in exorbitant pay. 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 dining expense account (instead of country club membership). He called public questioning of his compensation "petty" – and later resigned.

7. Defrauding our government and public health programs

News flash: Health insurers participating in public programs like Medicare and Medicaid don't always have the public interest in mind. A number have been charged with raking in public money for services they never delivered.

A New York investigation uncovered managed care companies charging duplicate premiums and billing for dead and nonexisting patients. In, Florida state and federal agents raided the offices of two HMOs to investigate whether they were really spending as much on mental health services as they reported. And, in 2005, Americhoice of Pennslyvania – now part of UnitedHealth Group – settled with the state over charges it had misled the state about claims, dragged its feet with payment to providers, and denied patients care they had a right to receive.

6. Using non-profit health care dollars to prop up for-profit subsidiaries

Every year, health insurance companies squirrel away billions of dollars in surplus. But can all that money really be just a cushion? In 2008, Premera Blue Cross, a Washington-based nonprofit health insurance company, funneled surpluses to a failing for-profit subsidiary in Arizona – while hiking 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."

5. Blocking approval and payment for covered services

Woops! It would be hard for PacifiCare 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. The laundry list of alleged health insurance misdeeds: wrongfully denying covered claims, failing to 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 blocked from scheduling surgeries for six months
- Over 200 patients of a single pediatrician being told he wasn't in the insurer's network anymore
- One father fighting for 11 months to get claims paid for his autistic child, while his wife put off EKG stress tests

4. Cutting payments to doctors, leaving patients to pay the difference

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 issued a fine against them of almost $9.5 million.

Aetna's not alone. Now, New York Attorney General Andrew Cuomo is investigating Aetna, UnitedHealth, CIGNA, and other health insurers for what he called "an industrywide scheme perpetuated by some of the nation's largest health insurers to deceive and defraud consumers."

3. Siphoning health care dollars away to feed corporate parent company profits

Think of $36.8 million as pocket change? Rhode Island's United Healthcare of New England wanted to send this sum as an "extraordinary dividend" to its Minnesota-based parent company, United HealthCare Services – itself a subsidiary of the giant UnitedHealth Group (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?

2. Manipulating preexisting condition rules to deny claims and care

It's bad enough that insurance companies are allowed to block health care for patients' "preexisting conditions." Making matters worse is health insurance companies' manipulation of this loophole to deny claims they're supposed to be covering under their own agreements.

Just look at Assurant, ordered by the Connecticut Insurance Department in 2007 to pay restitution to patients whose claims were improperly squashed by the company's subsidiaries, based on supposed 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."

And the denials weren't happening just in Connecticut. From the AG'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."

1. Using front organizations to sell shoddy, bare-bones products

When you're an independent businessperson, getting good health insurance is especially tough. An organization like the National Association for the Self-Employed (NASE) should help, right? It turns out that the NASE functions as a front for MEGA Life and Health and related companies – all the subject of a multi-state investigation and now infamous around the country for shady sales practices, leaky-bucket coverage, and trails of unpaid bills leaving financially strapped customers high and dry. MEGA has faced fines from Delaware to Washington state.

Think MEGA Life is an outlier in the industry? William Gedwed, Chairman, President, and CEO of MEGA parent company HealthMarkets, sits on the Board of Directors of America's Health Insurance Plans (AHIP), the industry's lobby arm. He must be watching out for the public good.