CALIFORNIA DEPARTMENT OF INSURANCE
LEGAL DIVISION
Health Enforcement Bureau
Andrea G. Rosen, Esq. SBN116600
300 Capitol Mall, 17th Floor
Sacramento, CA 95814
(916) 492-3508 Phone
(916) 322-1335 Facsimile
rosena@insurance.ca.gov

Attorneys for The California Department of Insurance

BEFORE THE INSURANCE COMMISSIONER

OF THE STATE OF CALIFORNIA

SACRAMENTO

In the Matter of the Certificate of Authority of: **ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY** Respondent.	File No. OSC- 2008-00014 **ORDER TO SHOW CAUSE, NOTICE OF HEARING, AND NOTICE OF MONETARY PENALTY** (Insurance. Code Sections 700, 704, 790.03, 790.035, and 790.05) **ACCUSATION / STATEMENT OF CHARGES** (Insurance Code Sections 700(c), 700(d), 704(b), 790.02, 790.03, 796.04, 10113, 10380, 10381.5, 10382, 10384, and 10400)

JURISDICTION AND PARTIES

The Insurance Commissioner of the State of California (Commissioner), acting in his official capacity, brings this matter pursuant to the provisions of California Insurance Code §§700(d), 704 and 790.05. As set forth herein, the Department alleges violations of Insurance Code §§700(c), 704(b), 790.03, 796.04, 10113, 10380, 10381.5, 10382 and 10384[1].

1. Respondent, ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY (hereafter "ANTHEM") holds a Certificate of Authority to transact the business of

[1] All statutory references are to the California Insurance Code unless otherwise indicated.

life and disability insurance in the State of California pursuant to §700 et seq. of the California Insurance Code.

2. ANTHEM, domiciled in California, is a wholly-owned subsidiary of WellPoint Inc.

3. On October 4, 2007, The California Department of Insurance (hereafter "the Department") issued an amended Certificate of Authority changing Respondent's name to Anthem Blue Cross Life and Health Insurance Company from its former name BC Life and Health Insurance Company.

GENERAL STATEMENT

4. On May 6, 2006, the Department's Field Claims Bureau undertook a targeted market conduct examination of ANTHEM'S practices relating to rescissions of policies held by former insureds under ANTHEM'S Individual and Family Plan Preferred Provider Organization insurance offerings. The Department's examination included a review of a sample of rescission files, rescission-related denied claims and member's appeals of rescission for the time period of January 1, 2004 through February 28, 2006, hereafter referred to as the "review period". This review included analysis of ANTHEM'S policies and procedures in handling rescissions and associated documents and a review of certain insurance policy provisions and health history questionnaires. The purpose of the examination was to ascertain ANTHEM'S compliance with the Insurance Code and the Fair Claims Settlement Practices Regulations of Title 10, Chapter 5, Section 2695.1 et seq. of the California Code of Regulations. The Department prepared reports based on the targeted market conduct examination on May 4, 2007 (hereafter "The Reports"); one was published on the California Department of Insurance website pursuant to §12938. The final reports were delivered to ANTHEM upon completion in 2007.

5. During the review period, ANTHEM rescinded 1880 individuals who were covered under individual and/or family plan insurance policies. The Department's examiners reviewed 93 files of insureds whose policies were rescinded during the review period, hereafter "rescission files".

6. In The Reports referenced in paragraph 4, the Department cited violations of §10380 which prohibits an insurer from denying benefits under a policy based on a false statement in an

application for coverage unless the statement materially affected the insurer's acceptance of the risk. The Department alleges that in each of these instances ANTHEM failed to demonstrate that the applicant had knowledge of the alleged false statements and proceeded to unlawfully bar recovery under the insured's policy in violation of §10380. An applicant must have knowledge of the information requested on an application in order to make a false statement regarding such information.

7. The Department recognizes ANTHEM'S efforts to comply with rescission laws undertaken prior to the issuance of this Accusation including submission to the Department's Policy Approval Bureau of an improved individual health insurance application that provides greater clarity and ease of use for the applicant and facilitates improved medical underwriting by ANTHEM. The Department recognizes ANTHEM'S voluntary use of an Independent Third Party Review entity for review of proposed rescissions and ANTHEM'S commitment to act only upon recommendation of the Independent Third Party reviewer.

FACTUAL ALLEGATIONS

As a result of findings in The Reports referenced in paragraph 4 and the Department's analysis and investigation of consumer complaints received since January 1, 2004, the Department alleges that ANTHEM has violated the following provisions of the California Insurance Code: Sections 790.03(h), 796.04, 10113, 10380, 10381.5, 10382 and 10384 as described below.

8. In The Reports referenced in paragraph 4, ANTHEM was found to engage in prohibited postclaims underwriting in six cases in violation of §10384. Specifically, ANTHEM failed to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with the application before issuing the policy.

9. In 32 instances cited in The Reports referenced in paragraph 4, ANTHEM violated §790.03(h)(5) by failing to effectuate prompt, fair and equitable claims settlements in which liability had become reasonably clear. Specifically, ANTHEM based one of its rescissions in part on a medical condition that the applicant had clearly reported on the submitted health history questionnaire/application. Had ANTHEM met the required statutory standard set out in §10384

to complete medical underwriting and resolve all reasonable questions arising from or on the written application before issuing the insurance policy, it would have known of the reported medical condition prior to issuing the policy and could have underwritten this information. In another instance, the applicant revealed a medical condition to the agent who was assisting in completing the application but the agent assured the applicant that their condition was not a problem. ANTHEM subsequently rescinded the insured when a claim was presented for that same medical condition yet never followed up with the agent to verify the insured's claim that this condition was reported to the agent. ANTHEM'S instructions to its agents clearly prohibit an agent from interfering with the applicant's attempt to truthfully and accurately complete the application for health insurance coverage.

10. In 27 instances cited in The Reports referenced in paragraph 4, ANTHEM violated §790.03(h) (3) by failing to adopt and implement reasonable standards for the prompt investigation and processing of claims stemming from rescissions. ANTHEM acknowledged understaffing their Medical Investigation Unit in 2004 and 2005 which resulted in unacceptable delays in notifications to insureds and providers as well as delayed claims processing. ANTHEM'S understaffing of this unit resulted in serious delays in the completion of hundreds of rescission investigations, resulting in thousands of delayed and denied claims. The Department acknowledges that ANTHEM has increased staffing from 5 to 21 persons in an attempt to prevent future violations of this kind. ANTHEM has committed to more robust pre-issuance underwriting in an effort to avoid the volume of rescission investigations undertaken in 2004-2007. ANTHEM's practice of opening a rescission investigation and suspending claims processing without providing timely notice to insureds or affected providers followed by unreasonable delays in making a decision whether to rescind occurred with such frequency during the time period of 2004-2007 as to indicate a general business practice.

11. ANTHEM'S individual health insurance application which became part of the insurance policy when issued stated in pertinent part: *"I understand that if I intentionally provide incomplete or false material information that Blue Cross may revoke my coverage."* Under this provision, ANTHEM was required to prove that the insured had intentionally provided

incomplete or false information before ANTHEM could rescind the policy. The Department's examination of rescission files revealed that ANTHEM failed to prove that the insured intentionally provided incomplete or false material information. Instead of contacting the insured as part of making this determination, the Department alleges that ANTHEM incorrectly relied solely on its own interpretation of medical records to make such determinations of the insured's intent and did not verify with the insured that the insured had actual knowledge of the incomplete or false material information. ANTHEM'S failure to demonstrate that the insured had actual knowledge of the incomplete or false material information constitutes a failure to carry out its contracts in good faith in violation of §704(b). The Department alleges that ANTHEM violated §790.03(h)(1) by its failure to verify the insured's actual knowledge of the incomplete or false material information subsequently used as the basis for rescission.

12. Commencing on or before January 1, 2004 ANTHEM adopted and pursued a general business practice of accepting an application for health insurance coverage that was incomplete and/or contained contradictory or conflicting information on its face and then failed to resolve the contradictions prior to issuing a health insurance policy. The Department alleges that this business practice resulted in ANTHEM'S failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with the application and violates §10384. After issuing the policy ANTHEM initiated a rescission investigation, usually triggered by receipt of a claim. During this postclaims investigation rather than during the pre-issuance underwriting, ANTHEM inquired about the insured's medical history usually by obtaining medical records, only then discovering what it could have learned had it completed medical underwriting before issuing the policy.

13. As a general business practice, ANTHEM approved care or paid claims, then upon rescission of an insured's policy, routinely recouped payments and/or denied pending claims that arose while the insurance policy was in force. This routine business practice resulted in thousands of claims denied or recouped for care that it had approved or for coverage which it had

verified when the insurance policy was in force. The Department alleges that this general business practice violated §796.04.

ACCUSATION AND STATEMENT OF CHARGES

14. Based on the facts alleged herein, the Department alleges that ANTHEM has engaged in activities in violation of §§704(b), 10380, 10382 and 10384.

15. Based on the facts alleged herein, the Department alleges that ANTHEM has engaged in activities which constitute an unfair method of competition and /or unfair and deceptive acts or practices in this State in violation of §790.03(h) (1), (3) and (5).

16. Based on the facts alleged herein, the Department alleges that ANTHEM'S failure to pay claims it had approved prior to rescinding an insured's coverage violated §796.04.

17. The Department alleges that ANTHEM engaged in prohibited postclaims underwriting as defined in §10384 and such conduct constitutes a failure to comply with the requirements as to its business as required by §700(c).

ORDER TO SHOW CAUSE PURSUANT TO §790.05

18. Based on all of the facts alleged herein and the Department's findings in both of its Reports as referenced in paragraph 4 and its investigations of consumer complaints, the Commissioner has reason to believe that ANTHEM has engaged in activities and business practices which constitute an unfair method of competition and/or unfair or deceptive acts or practices in this State in violation of California Insurance Code §790.03(h) and which constitute grounds for the assessment of penalties and/or fines as authorized by law pursuant to §790.035 and §790.08.

19. The Commissioner believes that a proceeding would be in the interest of the public and issues this Order to Show Cause pursuant to §790.05 which contains a Statement of Charges, a Notice of Monetary Penalty and a Notice of Hearing.

20. The Department notifies ANTHEM that, based on the facts alleged herein and the alleged violations of §790.03, demand is made for the imposition of monetary penalties pursuant to §790.035 which permits a fine not to exceed $5000 for each act or practice that is not willful or a fine not to exceed $10,000 for each act or practice that is willful.

21. The Commissioner now notifies ANTHEM that a hearing shall be held at a time and place to be determined by the Department which shall not be less than 30 days after service of this Order to Show Cause to determine whether the alleged acts and practices set forth herein are unfair acts or practices as prohibited by §790.03(h) and whether the Commissioner should issue an Order requiring ANTHEM to pay the penalty imposed pursuant to §790.035 and to cease and desist from such practices.

REQUEST FOR ORDER, MONETARY PENALTY AND OTHER RELIEF

WHEREFORE, the Insurance Commissioner prays for judgment against ANTHEM as follows:

1. An order to immediately Cease and Desist from engaging in activities in the business of life and disability insurance in violation of §§700(c), 790.03, 796.04, 10380, 10382 and 10384.

2. Pursuant to §790.035, for unfair acts or deceptive acts or practices as set forth herein, a penalty in an amount to be fixed by the Commissioner not to exceed $10,000 for each unfair or deceptive act or practice found to be willful and a penalty in an amount to be fixed by the Commissioner not to exceed $5,000 for each unfair or deceptive act or practice not found to be willful.

3. Full restitution and/or reimbursement for acts or omissions in violation of statutes cited above.

4. Appropriate remedies as provided for in §704 and §10400.

5. Costs incurred by the Department in bringing this action and any future costs to the Department in ensuring ANTHEM'S compliance with the Insurance Code.

Dated: February 6, 2009

STEVE POIZNER
Insurance Commissioner

By:
ANDREA ROSEN
Staff Counsel

In the Matter of the Certificate of Authority of:	)	DECLARATION OF SERVICE BY U.S. MAIL
ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY	)	FILE NO. OSC-2008-00014
Respondent.	)	

I am over the age of 18 years, and not a party to this cause.

I am an employee at the Department of Insurance, State of California, employed at 300 Capitol Mall, Suite #1700, Legal Division, Sacramento, CA., 95814.

On February 9, 2009, at Sacramento, California, I sealed into an envelope and deposited in the U.S. Mail, postage there upon fully prepaid, true copies of the following documents in the above-entitled matter; the original, or a true copy, of each document served is attached hereto; said copies were addressed as follows:

c: ORDER TO SHOW CAUSE, NOTICE OF HEARING, AND NOTICE OF MONETARY PENALTY and ACCUSATION/ STATEMENT OF CHARGES and DECLARATION OF SERVICE BY U.S. MAIL were mailed to:

U.S. CERTIFIED AND REGULAR MAIL
7006 3450 0003 8140 1699

Karen Francolini
Managing Associate General Counsel
Anthem Blue Cross Life and Health Insurance
21555 Oxnard Street
Woodland Hills, CA 91367

I declare under penalty of perjury that the foregoing is true and correct.
Executed on February 9 2009, at Sacramento, California.

Elizbeth A. Bach

Elizbeth A. Bach

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