California Health Insurers Are Punished With Fines Totalling Nearly $5 Million

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Nov. 30--California's top health insurers are being fined nearly $5 million after an 18-month state audit uncovered improperly paid claims to thousands of doctors and hospitals, an official announced Monday.

The state's seven biggest health insurance companies will also need to pay restitution -- estimated to be in the tens of millions of dollars -- after the audit found that they underpaid care providers or failed to pay them on time, according to the state Department of Managed Health Care.

"Providers are struggling to stay afloat in a very difficult business environment," department Director Cindy Ehnes said Monday during a morning news conference at Providence Saint Joseph Medical Center in Burbank. "Improper payment of provider claims runs the risk that our health care delivery system could grind to a halt."

Anthem Blue Cross and Blue Shield of California were fined $900,000 each. Aetna was fined $300,000; Cigna was fined $450,000; HealthNet and Kaiser Foundation Health Plan were fined $750,000; and PacifiCare/United Health was fined $800,000.

The insurers are required by law to pay 95 percent of their claims correctly, but instead were only properly paying about 80 to less than 95 percent of their claims, according to auditors.

"Patients expect health plans to pay claims to doctors and hospitals fairly and promptly so they can get the care they need," said Anthony Wright, executive director of Health Access California, a statewide health care consumer advocacy coalition. "Consumers would rather that the time and resources of health providers go to patient care, rather than in fighting to get insurers to pay correctly."

Appeal and dispute processes at five of the seven insurers -- all except Anthem and Blue Shield -- were also flawed, according to the DHMC. Providers trying to dispute claims would often end up contacting the same department that denied their claim in the first place, Ehnes said.

"The second time they go to bat, they're just denied summarily through that same process," Ehnes said. "Then it is a meaningless process."

Hundreds of thousands of claims may be affected, but the exact number is unclear because the audit used statistical samples of each insurer's claims, Ehnes said.

The health plans will work to meet regulation requirements and improve performance, said Patrick Johnston, President and CEO of California Association of Health Plans, speaking on behalf of the insurers.

"We have long recognized that the administrative side of health care coverage can take valuable time away from patient care, which is why plans have been working to streamline processes both at the health plan level and in doctors' offices," Johnston said.

Plans have agreed to corrective actions and are tweaking their payment processes, adding more staff and resources, providing additional management and oversight and revamping internal processes.

The investigation was launched in 2008 after a provider told Ehnes that an insurance claim was not a guarantee of payment, but a "ticket to chase those dollars," Ehnes said.

"That is unacceptable," Ehnes said. "If providers are not paid, patient care and access suffers."

The fines are the latest in a series levied against several of the providers named Monday.

In 2008, DMHC fined PacifiCare $3.5 million for not paying claims on time.

Earlier this year, Anthem was fined $1.6 million after seven hospitals were denied claims. The DMHC ordered the insurer to change the way it handled "stop-loss" payments, which cover care in excess of the contracted daily rate paid to by the plan to a provider. Since then, denied stop-loss payments have dropped 50 percent a year for the past two years, according to the DHMC.

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