Issue BRIEF

Fighting Revocations and Limitations of Health Insurance Policies

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One of the most appalling insurance company practices is that of revoking an individual's health insurance policy or suddenly eliminating coverage for crucial health services long after the person has enrolled. People believe that when they buy insurance—just as when they enter into any other contract—the insurer has completed any investigation it wants to conduct regarding whether to issue a policy, and that the policy will pay for the health care they need. In some cases, however, people have paid insurance premiums for months or even years before they required medical services, at which point their insurance company decided to reexamine their medical histories and dramatically change or completely revoke their policies. This abusive practice, sometimes called "post-claims underwriting," has been documented in several court cases and state investigations.

There are essentially two ways that insurance companies conduct post-claims underwriting, and below we provide two examples that illustrate how this usually takes place:

1. An individual completes an insurance application and is sold a policy that excludes coverage of "pre-existing conditions" for a year (or maybe longer, depending on what state law allows). However, the contract does not specify which conditions are considered to be pre-existing conditions, nor does it specify which treatments the policy would not cover for that year. The person becomes ill during the first year of the policy, and the insurer decides to review the application, digs back through years of medical history, and determines that the current (often expensive-to-treat) illness is related to one of those pre-existing conditions. The insurer then refuses to pay claims related to the current illness.
2. An individual completes an application for insurance and is sold a policy. After the person becomes ill, the insurer reviews the application again and digs through years of medical history. The insurer determines that, at the time the person applied for the policy, he or she had a medical condition that was not disclosed on the application. Perhaps the person knew about the condition and neglected to mention it, perhaps the person did not understand from the application that this information was required, or perhaps the person was unaware that he or she had a medical condition, although that information was in his or her medical record. In any case, the insurer revokes the policy and

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retroactively cancels coverage, claiming that it would not have sold the policy in the first place had it known about the condition. In some instances, the alleged omission has very little (if anything) to do with the health problem that led the insurer to conduct a second review. For example, a cancer patient's policy could be revoked because she did not reveal that she had taken an antidepressant five years before buying insurance.

What Can Consumers and Advocates Do about Post-Claims Underwriting?

- ### Prevent the Problem (as much as possible)
  - Insurers should be required to use simple, straightforward health insurance applications, and individuals should answer questions on these applications as truthfully and completely as possible.
  - Advocates can push for good state laws regarding individual and family health insurance, when companies must provide coverage, and state oversight of insurance company behavior.

- ### Consumers Should Know Their Rights
  - **In all states, health insurers must abide by the federal Health Insurance Portability and Accountability Act (HIPAA).** This law states that insurers must continue individual insurance policies, and renew them, unless a person (a) stops paying premiums, (b) moves out of the health plan's service area, (c) commits fraud, (d) ends membership in an association that made the coverage available, or (e) if the plan stops selling the coverage in the individual market.

    The rule states that a person can be dropped for fraud only if "The individual has performed an act or practice that constitutes fraud or made an *intentional* [italics added] misrepresentation of material fact under the terms of the coverage" (45 Code of Federal Regulations, Section 148.122).

    If an insurer cancels such a policy for any other reason, it may be illegal under federal law. However, if the insurance company asserts that it never should have issued the policy in the first place, there are some gray areas in HIPAA, and the individual may want to get an attorney's advice.

  - **States may have additional laws** to protect consumers. Individuals should talk to their state insurance department and to health care advocates about any other laws in their state that may help.

- **If an individual believes that his or her insurance policy is being unfairly revoked or limited, the person should do the following:**
  - file a formal complaint with the state department of insurance,
  - get help from any consumer assistance programs that exist in the state that help people deal with health insurance problems (some are listed online at http://families usa.org/resources/program-locator), and possibly
  - consult an attorney.

  State insurance departments can order companies to reinstate coverage if it was wrongfully terminated and may be able to fine the companies for violating state laws. By filing lawsuits, some consumers have won both reinstatements and money in damages when their policies were wrongfully revoked.

- **States and the federal government have laws against unfair and deceptive marketing**. If a person bought a policy that said it would cover treatment, but the policy was revoked once the person actually needed treatment, the insurer may have engaged in unfair and deceptive marketing. Consumers should talk to their state attorney general and/or their district or city attorney to see if these offices can help. Within the attorney general's office, there may be a "consumer protection division" or a "health care bureau" that answers questions and goes to bat for consumers.

  By filing civil lawsuits on behalf of the public, attorneys general (and, in some places, district or city attorneys) may be able to force insurers to stop a pattern of deceptive practice and restore policies that have been wrongfully revoked.

Advocates Should Push for Any Needed Improvements in Their State Laws to Protect Consumers against This Kind of Abuse

- **States can prohibit or limit insurers from denying applicants based on health status**.

  States can require insurers to sell policies to all applicants regardless of health status (called guaranteed issue). In such states, insurers are not able to later revoke policies if they obtain further information about a person's health status (if a person is in an accident or becomes ill, for example). Even if a state does not want to provide guaranteed issue, states can set criteria regarding whom the plan must accept or can reject. For example, some states require plans to use a standardized application for insurance. In these states, the state creates a list of serious medical conditions, and only people with those conditions can be rejected by private insurers. (People with those listed conditions can get coverage through a state-designated plan, such as a high-risk pool.) This gives the state more oversight over insurers' decisions.

- **States can put limits on what previous medical history is relevant to an insurance application and how long treatment for pre-existing conditions is excluded**.

  Three kinds of limits are important:

  1. If they allow insurers to reject applicants based on health status, states should restrict insurers to asking only about the last three months or the last six months of a person's medical history when determining whether to issue a policy.

  2. States should restrict insurers to asking only about the last three months or six months when determining whether to exclude coverage for a particular pre-existing condition. If states allow pre-existing condition exclusions at all, they should allow insurers to exclude only conditions that were diagnosed or treated by a medical professional, or for which a medical professional recommended treatment, shortly before the consumer bought the insurance policy. This is known as an "objective standard."

  States should not give insurers the discretion to exclude coverage based on subjective judgments about whether a person might have had symptoms before buying the policy that should have led the person to seek treatment. This kind of leeway involves too much second-guessing and is bound to harm consumers.

  3. States should limit the length of time that a pre-existing condition can be excluded from coverage after a person buys a policy. For example, some states allow insurers to deny treatment of a pre-existing condition for only six months, and they shorten or eliminate this waiting period if the person was previously covered by another insurer. It is important to note that even a six-month waiting period is too long for many consumers, who often cannot afford to pay premiums when the treatment they need is not even being covered by their insurer.

  Pre-existing condition exclusions are designed to keep consumers from gaming the system and waiting until they are sick to buy policies, but they can be terribly harmful to consumers. Advocates may be able to come up with other ways to encourage healthy people to purchase health insurance that are less harmful to consumers. Options range from facilitating enrollment to good outreach for affordable products, late enrollment penalties, and individual mandates.

- **States can require insurers to explain in writing what their policies will cover and what coverage is being excluded, even for a limited period of time, when they issue policies.**

  Instead of allowing insurers to add vague language to contracts that states that coverage for unnamed pre-existing conditions will be excluded for a period of time, states can require insurers to specify in the policy any conditions for which they will exclude treatment and the date that the exclusion ends.

- **States can require the use of clear, understandable insurance applications.** As noted earlier, states can require the use of standard applications, or at least require that insurers submit their application forms to the insurance department for review. Some states require the completed application to be attached to the insurance contract. That way, if there are disputes later about whether a consumer intentionally misrepresented facts on an application, all parties can examine both questions and responses and how they do or do not affect the terms of the insurance contract.

- **States can require insurers to complete all medical underwriting at the time of an application.** If an insurer has questions about a person's prior medical history, the insurer should investigate the questions before writing a policy. And the insurance contract should disclose the full terms of coverage. Insurers should not wait until someone gets sick to investigate a person's medical history.

- **States can prohibit insurers from limiting or revoking coverage unless the insurer demonstrates "willful" misrepresentation and intent to deceive.** States can insist that revocations occur only in exceptional circumstances where there is clear proof of fraud.

- **The state should review in advance any requests by insurers to limit or revoke coverage.** State regulators are in a better position than insurers to examine allegations of fraud or misrepresentation, since they do not have a financial stake in the matter.

- **When coverage is wrongfully terminated, states can require insurers to take action to remedy the situation.**

  1. States can require insurers to pay all past claims for consumers whose coverage was wrongfully terminated. States should make this process as simple as possible, rather than setting up protracted procedures in which the insurers contest the validity of each medical bill.

  2. States can require insurers to reinstate coverage that was wrongfully terminated. This kind of requirement is extremely important, since by the time the consumer's coverage is revoked, the consumer has become ill and will therefore likely be denied policies by other insurers. The consumer must be able to get insurance again from the company that revoked his or her policy.

  3. States can sanction health insurance plans when appropriate, particularly when rescissions have become a pattern of practice.

Other Issues to Consider

■ Who should hear appeals about revocations of coverage?

Some states now use "independent review organizations," which are comprised of medical experts, to hear disputes about whether care is medically necessary, and America's Health Insurance Plans (AHIP, the trade organization for insurance companies) supports a similar external review process for disputes about policy revocations and limitations. But are these organizations the best entities to hear disputes about policy revocations? If they are comprised of medical professionals instead of judges, the may not be. The issues in dispute in these cases are more likely to involve what the consumer understood about the application, whether the consumer willfully or accidentally omitted information on the application, whether the insurer did its job of investigating the application initially and informing the consumer about the terms of coverage, and whether the consumer's medical history was actually relevant to whether the insurer should pay for current treatment. On the other hand, some discrete issues come up in these cases on which medical experts might weigh in, including whether there is any medical connection between a current problem and previous medical history.

Some advocates believe that external review organizations develop too cozy a relationship with insurance companies over time: For example, an insurer may lobby state agencies and state legislators when an external review organization's contract is up for renewal, arguing against renewal if the reviewers have ruled against the insurer often. Although insurance department regulators may also be subject to influence by insurance companies, at least they can be called into oversight hearings before the state legislature and held accountable in the press. Politics and organizational structures of insurance departments may differ from state to state, and advocates will need to determine what best serves the consumers in their state.

■ How can advocates enlist health care providers to advocate for their patients?

When a consumer's coverage is limited or revoked, doctors and hospitals are often left with unpaid bills. They can thus be allies in an advocate's quest for better state laws. They can also testify for their patients, explaining the difficulty of determining whether a symptom that a patient experienced before purchasing a policy was significant, whether it is relevant in any way to the patient's current problem, and about the hardship the patient now faces.

In California, a law protects doctors and patients by requiring insurers to pay for all care that had been authorized prior to a revocation, thus preventing insurers from retroactively denying payment. However, it is important to keep doctors involved in all laws that prevent and remedy insurance revocations, even if their own bills are paid. Thus, passing a law that pays only patients' back medical bills, without addressing the overall practice of revocations, may be bad legislative strategy.

- ## Should your state prohibit "elimination riders"?

  Some states allow insurance companies to exclude coverage of named conditions forever, known as elimination riders, as long as the companies attach specific riders to the policies they issue that clearly state those exclusions. For example, a rider might state that the insurer will never cover Jane Doe's injured back or her diabetes. Some argue that these riders allow people to at least buy some insurance when they would otherwise be denied, or that these riders allow them to buy less expensive policies than their health conditions would otherwise allow. But selling policies with elimination riders is tantamount to a guarantee that consumers won't get coverage for certain services that they need.

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