HEALTH POLICY MEMO
June 2008

Post-Claims Underwriting Survey

In April and May 2008, as part of a larger survey on state health insurance regulations, Families USA surveyed all state insurance departments regarding laws in their states that prohibit insurers from limiting or rescinding health insurance policies after they have been issued. In this memo, we share some of our survey findings. The first section reports on state responses to our questions. The second section contains excerpts of some of the better state laws and regulations. It is important to note, however, that as described in the second section, even when states replied that they protect consumers against post-claims underwriting, we found that many of their laws are not explicit and should be strengthened.

State Survey Responses

1. Does the state require that insurers complete all medical underwriting and resolve all questions at the time of application?

- The following 13 states replied yes: CA, CO, CT, FL, IN, MD, NH, NM, OH, PA, RI, VA, and WA.
- The following three states replied that, while their insurance laws are not explicit, they do enforce such a policy (for example, as part of fair marketing practice requirements): AL, NE, and OR.
- Five states with guaranteed issue and community rating (ME, MA, NJ, NY, and VT) generally replied that this question does not apply to them, since insurers cannot base acceptances or rates on medical information. Though we believe there may still be disputes about the application of pre-existing condition limitations in these states, we did not probe further.
- The remaining 29 states and the District of Columbia replied that they have no such requirement.

2. Does the state require insurers to notify policyholders in advance about what conditions will not be covered?

- About 13 states replied that they had no such requirement.
- When we probed further into states that said they required advance notice, we learned that states understood this question in different ways: A number of states do not require temporary exclusions to be specifically named in contracts if insurers give a general notice that pre-existing conditions will be excluded for a certain period of time (named in state law, often 12 months). However, if conditions are going to be excluded for a longer period of time, insurers must attach specific exclusionary riders. Some states told us about their

requirements for insurers to provide consumers notice when the companies were changing the benefits in a particular insurance product. Since our question was unclear, we are not reporting state responses.

3. Does state law or regulation require insurers to obtain the state's permission in advance to revoke coverage of individual policyholders due to medical history?

- Only Connecticut has such a requirement.

4. Does the state give consumers appeal rights if their policy is rescinded?

- Eighteen states and the District of Columbia report that they give consumers appeal rights if their policy is rescinded (CA, CT, DC, FL, ID, IL, IN, LA, MD, MN, MO, MT, NE, NV, NM, OR, RI, WA, and WI). We did not probe further to determine the nature of the appeals processes. We suspect that some of these involve formal hearings at the insurance department, others use independent review organizations, and others may be informal procedures. Furthermore, in some of these states, people have appeal rights only if they are enrolled in certain plans (for example, people enrolled only in managed care plans).
- An additional eight states told us that, though it is not through a formal appeals process, they will investigate consumer complaints if coverage is rescinded (KY, MI, ND, OK, SC, SD, TN, and TX).
- This question was not applicable in the five guaranteed issuance states (ME, MA, NJ, NY, and VT).
- In 19 states, consumers do not have appeal rights through their state if their coverage is rescinded. State regulators in AR, CO, and NC reported that they require insurers to have an appeals process, but regulators did not indicate that the department of insurance or another state entity offers an appeals process.

State Laws and Regulations

As noted earlier, even if their laws are not explicit on this subject, a number of state regulators believe they have the authority to require that insurers complete all underwriting and resolve all questions at the time of application and that they provide specific advance notice to consumers about coverage limitations and exclusions. The regulators also believe they have the authority to hear consumer appeals of revocations. We agree that regulators should be aggressive in investigating abusive post-claims underwriting. Laws that prevent unfair and deceptive marketing, as well as federal HIPAA legislation, give them some grounds to do so, but more explicit state laws would also help.

Below we list some examples of the clearest laws and regulations that we found that protect consumers from abusive practices.

■ Health Insurance Applications

Consumers may understand neither the questions being asked of them on insurance applications nor the consequences of giving incomplete information. Some states, such as California, are now considering regulatory requirements that insurers ask clear questions on applications.

California's proposed managed care rules (section 1300.89.3) require the insurance plan, before issuing a subscriber contract, to:

- Review the responses in, or submitted with, a coverage application to identify, at a minimum, responses that appear inconsistent, ambiguous, or incomplete, or that indicate that the applicant may have misunderstood the question; and
- Obtain and review additional information that is necessary to resolve such questions that are reasonably apparent in the application and reasonably related to the plan's medical underwriting process.

A few states require that all insurers use a uniform health insurance application.

- In **Utah** and **Washington**, insurers must use uniform medical underwriting criteria and procedures. If an insurer does not accept an applicant for coverage, individuals can enroll in the states' high-risk pools.
- **Oregon** does not require uniform acceptance criteria, but it still requires a uniform application:
- Oregon Standard Health Statement (OAR 836-053-0510: The Oregon Standard Health Statement is the only health statement that a carrier may use to evaluate the health status of applicants for coverage in an individual health benefit plan and for late enrollees in a group health benefit plan.

Look-Back Periods and Objective Definitions of Pre-Existing Conditions

As reported on the Kaiser Family Foundation's State Health Facts Online Web site (www.statehealthfactsonline.org), **New Hampshire** uses the shortest look-back period, allowing insurers to investigate a maximum of three months of an applicant's medical history to determine whether a condition is pre-existing. Eighteen states define a pre-existing condition as a health condition that a health care provider has treated or recommended treatment for during the look-back period (as opposed to a condition that a "prudent person" should have realized required treatment). This more objective standard better protects consumers.

Requirements to Complete Medical Underwriting at the Time of Application and Provide Notice to Policyholders of What Is Covered

- **California**
  - Existng Laws:
    For the Department of Insurance:
    § 10384. No insurer issuing or providing any policy of disability insurance covering hospital, medical, or surgical expenses shall engage in the practice of postclaims underwriting. For purposes of this section, "postclaims underwriting" means the rescinding, canceling, or limiting of a policy or certificate due to the insurer's failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the policy or certificate.

For the Department of Managed Health Care:
§ 1389.3. Post-claims underwriting: No health care service plan shall engage in the practice of post-claims underwriting. For purposes of this section, "post-claims underwriting" means the rescinding, canceling, or limiting of a plan contract due to the plan's failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the plan contract. This section shall not limit a plan's remedies upon a showing of willful misrepresentation.

Further, the policy must include "appropriate captions, in boldface type, for…exclusions," and the plan materials must disclose "exceptions, reductions, and limitations that apply to the plan."

NOTE: Though California statute forbids insurers from rescinding, canceling, or limiting a policy that has already been issued unless the plan shows that an individual "willfully" omitted or misrepresented a medical condition in order to receive coverage, a number of recent California lawsuits allege that major health plans in the state systematically seek out innocent omissions and mistakes on applications and use these to cancel coverage after claims have been filed.[a] Over the past year, the Department of Insurance and the Department of Managed Health Care have each conducted investigations and fined insurers for wrongfully rescinding numerous policies.

To respond to these continuing problems, California proposed stronger regulations that would require insurers to ask clear questions on insurance applications, contact applicants, or review additional health information to clarify any confusing or incomplete answers before issuing a policy, give consumers notice and the opportunity to participate in any investigations about whether they willfully misrepresented their health on applications, and provide for both internal and external appeals of rescissions. California lawmakers also passed new legislation in 2007 to prevent insurers from refusing to pay providers for treatment that they have already authorized when policies are canceled.

- **Minnesota**
  - Existing Law:

    62A.615 Pre-existing conditions disclosed at time of application: No insurer may cancel or rescind a health insurance policy for a pre-existing condition of which the application or other information provided by the insured reasonably gave the insurer notice. No insurer may restrict coverage for a preexisting condition of which the application or other information provided by the insured reasonably gave the insurer notice unless the coverage is restricted at the time the policy is issued and the restriction is disclosed in writing to the insured at the time the policy is issued.

- **Connecticut**
  - Existing Law:
    Public Act 07-113: (a) Unless approval is granted pursuant to subsection (b) of this section, no insurer or health care center may rescind, cancel or limit any policy of insurance, contract,

evidence of coverage or certificate that provides coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 of the general statutes on the basis of written information submitted on, with or omitted from an insurance application by the insured if the insurer or health care center failed to complete medical underwriting and resolve all reasonable medical questions related to the written information submitted on, with or omitted from the insurance application before issuing the policy, contract, evidence of coverage or certificate. No insurer or health care center may rescind, cancel or limit any such policy, contract, evidence of coverage or certificate more than two years after the effective date of the policy, contract, evidence of coverage or certificate.

■ Cancellations for Misstatements and Willfully Fraudulent Statements

Kentucky and **Virginia** specify that only misstatements that are relevant to whether the insurer would have issued a policy in the first place can be taken into account later.

- **Kentucky**
  - Existing Law:

    304.14-110 Representations in applications: All statements and descriptions in any application for an insurance policy or annuity contract, by or on behalf of the insured or annuitant, shall be deemed to be representations and not warranties. Misrepresentations, omissions, and incorrect statements shall not prevent a recovery under the policy or contract unless either:

    1. Fraudulent; or
    2. Material either to the acceptance of the risk, or to the hazard assumed by the insurer; or
    3. The insurer in good faith would either not have issued the policy or contract, or would not have issued it at the same premium rate, or would not have issued a policy or contract in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the policy or contract or otherwise. This subsection shall not apply to applications taken for workers' compensation insurance coverage.

- **Virginia**
  - Existing Law:

    38.2-508.5 This section shall not prohibit adjustments to premium, rescission of, or amendments to the insurance contract in the following circumstances: D. This section shall not prohibit adjustments to premium, rescission of, or amendments to the insurance contract in the following circumstances: When an insurer learns of information subsequent to issuing the policy or certificate that was not disclosed in the underwriting process and that, had it been known, would have resulted in a higher premium level or denial of coverage. Any adjustment to premium or rescission of coverage made for this reason may be made only to [the] extent that it would have been made had the information been disclosed in the application process, and shall not be imposed beyond any period of incontestability, or

beyond any time period proscribing an insurer from asserting defenses based upon misstatements in applications, as otherwise may be provided by applicable law. Any such rescission shall be consistent with § 38.2-3430.3 regarding guaranteed availability.

Many states laws *do not protect* consumers against rescissions for misstatements during the first two years that the policy is in force. Common language in these state laws is as follows:

> *After two years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such period.*

States such as **New Mexico** have considered amendments to this language, as follows:

> *As of the date of issue of this policy, no misstatements, except willfully fraudulent misstatements, made by the applicant in the application for this policy shall be used to void the policy or to deny a claim for loss incurred or disability, as defined in the policy* (from Senate Bill 377).

States often provide insurers with the *option* of adding a clause to their contracts that makes them incontestable after two years. Since the clause is optional, the law does not fully protect consumers:

> *After this policy has been in force for two years during the insured's lifetime, the insurer cannot contest the statements in the application.*

Connecticut's law sets forth a stronger requirement:

> *No insurer or health care center may rescind, cancel or limit any such policy, contract, evidence of coverage or certificate more than two years after the effective date of the policy, contract, evidence of coverage or certificate.*

■ Insurance Commissioner Must Review and Approve Insurers' Requests to Limit or Revoke Coverage, and Consumers Can Request a Hearing

- **Connecticut**
  - Existing Laws:

    Public Act 07-113:

    > (b) An insurer or health care center shall apply for approval of such rescission, cancellation or limitation by submitting such written information to the Insurance Commissioner on an application in such form as the commissioner prescribes. Such insurer or health care center shall provide a copy of the application for such approval to the insured or the insured's representative. Not later than seven business days after receipt of the application for such approval, the insured or the insured's representative shall have an opportunity to review such application and respond and submit relevant information to the commissioner with respect to such application. Not later than fifteen business days after the submission of information by the insured or the insured's representative, the commissioner shall issue a written decision on such application. The commissioner may approve such rescission, cancellation or limitation if the commissioner finds that (1) the written information

submitted on or with the insurance application was false at the time such application was made and the insured or such insured's representative knew or should have known of the falsity therein, and such submission materially affects the risk or the hazard assumed by the insurer or health care center, or (2) the information omitted from the insurance application was knowingly omitted by the insured or such insured's representative, or the insured or such insured's representative should have known of such omission, and such omission materially affects the risk or the hazard assumed by the insurer or health care center. Such decision shall be mailed to the insured, the insured's representative, if any, and the insurer or health care center.

(c) Notwithstanding the provisions of chapter 54 of the general statutes, any insurer or insured aggrieved by any decision by the commissioner under subsection (b) of this section may, within thirty days after notice of the commissioner's decision is mailed to such insurer and insured, take an appeal therefrom to the superior court for the judicial district of Hartford, which shall be accompanied by a citation to the commissioner to appear before said court. Such citation shall be signed by the same authority, and such appeal shall be returnable at the same time and served and returned in the same manner, as is required in case of a summons in a civil action. Said court may grant such relief as may be equitable.

(d) The Insurance Commissioner may adopt regulations, in accordance with chapter 54 of the general statutes, to implement the provisions of this section.

Sec. 2. Section 38a-19 of the general statutes is repealed and the following is substituted in lieu thereof (effective October 1, 2007):

(a) Any person or insurer aggrieved by any order or decision of the commissioner made without a hearing may, not later than thirty days after notice of the order to the person or insurer, make written request to the commissioner for a hearing on the order or decision. The commissioner shall hear such party or parties not later than thirty days after receipt of such request and shall give not less than ten days' written notice of the time and place of the hearing. Not later than forty-five days after such hearing, the commissioner shall affirm, reverse or modify his previous order or decision, specifying his reasons therefor. Pending such hearing and decision on such hearing the commissioner may suspend or postpone the effective date of his previous order or decision.

(b) Nothing contained in this section or sections 38a-363 to 38a-388, inclusive, shall require the observance at any hearing of formal rules of pleading or evidence.

(c) The provisions of this section shall not apply to an order or decision of the commissioner made pursuant to section 38a-478n or section 1 of this act.

(d) Any order or decision of the commissioner shall be subject to appeal therefrom in accordance with the provisions of section 4-183.

Notice to Consumers of Appeals Process

Consumers should get notice of available appeals both as part of their policy materials and when the insurer takes action to limit or rescind a policy. New Mexico requires insurers to specify in their contracts that policy cancellations can be appealed.

- **New Mexico**
  - Existing Law:

    13.10.13.14 Information provided to enrollees and readability of mangaged care plan contracts: A. Each evidence of coverage or disclosure form offered to subscribers, enrollees, and prospective enrollees upon request by a health care insurer through its MHCP shall state in clear, accurate, and conspicuous language, in not less than 10 point font, written such that it can be easily understood by the average enrollee, and so that it comports with the requirements of the "Policy Language Simplification Law," Chapter 59A, Article 19 NMSA 1978, the following information:

    (6) A description of the following:

    (a) eligibility requirements for coverage, including a statement of conditions on eligibility for benefits;

    (b) conditions of cancellation, which shall include a statement that if an enrollee believes coverage was canceled due to health status or health care requirements, he or she may appeal termination to the superintendent.

- **California**

  California's proposed rules (section 1300.89.3, October 22, 2007 draft) would give consumers "notice and opportunity to participate in the plan's investigation, including mailing notice of the plan's investigation not less than 15 days before the effective date of rescission, cancellation, or limitation of the subscriber contract…. The notice shall fully and fairly disclose: the information under investigation; the actions the plan may take at the conclusion of its investigation … an explanation of how the subscriber may participate in the investigation…." The notice must also include the following statement, with the first sentence in 14 point bold font and the remainder of the paragraph in 12 point font: "You have the right to request a review by the Department of Managed Health Care if [Plan] cancels or rescinds your coverage…."

Conclusion

Consumers expect that when they receive insurance coverage, the insurer has completed the medical underwriting process, and they will be covered according to the terms of their insurance contracts. Unfortunately, most states allow (tacitly, if not explicitly) insurance companies to perform medical underwriting, or to conduct more stringent underwriting, long after a policy has been issued to a consumer.

[1] Horton v. Wellpoint Inc, Cal. Super. Ct. NO BC 341823; Hailey v. Blue Shield of California, Cal. Ct. App., No. G035579; Ticconi v. Blue Shield of California Life and Health Insurance Co., Cal. Ct. App. No. B1904277/30/07.