

Primer on
**Post Claims Underwriting
and Rescission Practices**

Findings from Texas in the Individual Health Insurance Market

Hilary Haycock
Meredith King Ledford
Peter Harbage, MPP

Harbage Consulting



Robert Wood Johnson Foundation

Post Claims Underwriting and Rescission Practices

Findings from Texas in the Individual Health Insurance Market

Following a growing number of anecdotal reports, there is increasing interest in obtaining a better understanding of post-claims underwriting. This “little known business practice”¹ has come to the attention of Rep. Henry Waxman, Chairman of the U.S. House of Representatives Committee on Energy and Commerce, as well as state and federal health insurance regulators. Post-claims underwriting is when an insurer investigates an individual or small group policyholder’s medical history after the policy has been issued, and in particular after claims are submitted. Insurers have said that post-claims underwriting prevents fraud and therefore helps keep premiums rates low. For individuals whose health coverage has been canceled after the onset of a serious medical condition, post-claims underwriting can have serious consequences for their health and financial well-being.

Both federal and state laws regulate post-claims underwriting practices, although states are primarily responsible for enforcing those regulations. This varying regulatory enforcement environment creates the possibility for individuals who made good faith premium payments to have their coverage wrongly terminated or rescinded (retroactive cancellation), as has been found in California.² The result is that those with insurance face uncertainty over whether it will be there when needed.

The Robert Wood Johnson Foundation is funding research to promote understanding of post-claims underwriting in insurance markets across America, which could then lead to improved state and federal laws to protect both consumers and insurers from fraud and unlawful actions. This brief explores what is known and unknown about post-claims underwriting, and state and federal insurance regulations around these issues.

Role of Underwriting

In most states, health insurance in the individual market is medically underwritten. Through underwriting, the insurer will evaluate the risk of each individual applicant to decide whether a policy should be offered and, if so, at what premium. From the insurers’ perspective, underwriting protects the insurance pool by preventing adverse selection, which is when those higher risk individuals who believe they may need health coverage are more likely to seek to purchase it. Adverse selection increases costs for all members of an insurance pool, by concentrating risk – and costs – which creates an even stronger disincentive for lower risk individuals to purchase coverage. Indeed, just 20 percent of the American population accounts for 80 percent of medical costs.³ Medical underwriting helps prevent this by helping an insurer determine:

- *If the applicant is eligible for coverage.* In a few states, and under some conditions, insurance companies are required to accept all applicants, a policy called guaranteed issue. In others, insurers can reject applicants based on their health status.

- *What rate to charge for coverage.* Insurers seek to vary the cost of insurance based on an individual's expected health costs. This is necessary for insurers to both maintain their economic viability and be able to offer insurance to lower risk individuals at rates they will be willing to pay.
- *If there are any coverage limitations to be applied.* Most states allow insurance companies in the individual market to attach riders to insurance policies that exclude certain medical conditions (or body parts and systems) from coverage. Medical underwriting would be used to identify those exclusions.

From the perspective of the applicant, underwriting is a burdensome, and sometimes confusing, process.⁴ To determine an individual's risk level, insurers will ask for multiple forms to be completed, previous medical records to be supplied, and sometimes will conduct health exams.⁵ There is no national standard for the underwriting process, and state regulations for insurance applications vary. For this reason, the underwriting process likely varies widely, but may include a review of past health claims, applications for individuals to self-report their health status or medical exams.

Post-Claims Underwriting Process and Outcomes

Although the purpose of medical underwriting is to assess an applicant's risk profile before coverage is issued, the process is not foolproof. In some cases, an applicant may have an incentive to conceal information about her health or risk status from an insurer in order to obtain coverage or terms of coverage that might otherwise not be issued. At the same time, an applicant might inadvertently fail to disclose information – for example, about health history in the distant past or concerning seemingly minor and unimportant health conditions or symptoms. Or, an applicant might be unaware of a health condition that is undiagnosed at the time she applies for coverage. It is also possible that insurers may not conduct sufficient medical underwriting at the time they issue a policy.

Preexisting Exclusions

In many states, insurers are allowed to exclude coverage for preexisting medical conditions – or the body parts and systems affected by the condition. The rules for how insurers can determine and impose these preexisting condition exclusions (or coverage limitations) are different in the individual market than in the small group market.

Preexisting condition definition: Federal law defines a preexisting condition in the small group market as a condition for which an individual received medical advice, a diagnosis, or treatment in the six months before joining a health plan. In contrast, the definition of preexisting conditions varies by state for the individual market. Eighteen states use the “objective standard” – which is similar to the small group definition – an individual must have received medical attention for the condition. Twenty-four states use the prudent person standard, a higher standard which defines preexisting conditions as any condition for which a prudent person would have sought medical care. This definition includes conditions not yet diagnosed. The remaining 8 states do not even have a definition of preexisting conditions, leaving it to internal insurer determinations.

Look-back periods: Whereas insurers can only use the past six months of an individual's medical history to identify a preexisting condition for any small or large group insurance policy, look-back periods in state individual markets range from 6 months or less in 15 states, to unlimited look-back periods in 13 states.

Exclusion period: In the group market, insurers can only limit coverage for 12 months (or less depending on the size of the group and state regulations), and must give policyholders credit for having continuous prior coverage. In the individual market, 38 states allow insurers to exclude the condition permanently. If the insurer chooses to limit coverage for a period of time, most states limit exclusion periods to 12 or 24 months, with just four states limiting exclusion periods to 9 months or less, and 9 states placing no limit on exclusion periods. Twenty-six states require insurers to give policyholders credit for continuous prior coverage.

SOURCE: Kaiser Family Foundation, State Health Facts, www.statehealthfacts.org

If a new policyholder makes claims for a serious or expensive medical condition during the first year of coverage, the insurer may investigate the claim to determine whether any of these underwriting failures took place. If an insurance company determines through post-claims underwriting that a policyholder has not provided all health information (regardless of the applicant's intent), or that their medical condition was preexisting, it can result in serious financial and coverage consequences for the individual and their family. What action the insurer will take depends not only on the intent of the applicant, but also on the insurer's own internal guidelines on how to act on the results of the investigation and on the content and enforcement of state laws.

- *Coverage Cancellation.* Individuals can find themselves, and possibly their whole family, uninsured. Losing your coverage in this way can make it harder to get new insurance, even from a different company.
- *Coverage Rescission.* A rescission is the retroactive cancellation of health coverage, meaning that not only is an individual's coverage cancelled, but the insurance company is no longer responsible for claims previously submitted. For individuals who have accumulated significant medical bills – the exact claims which prompted the post-claims underwriting – this can be a financial hardship or crisis.
- *Retroactive Coverage Riders.* Alternatively, insurers will sometimes maintain a policyholder's coverage, but will limit that coverage by retroactively imposing an exclusion rider or a rate increase.
- *Preexisting Condition Exclusion.* Insurers may exclude the preexisting medical condition for which the individual needs medical care. This can have the same effect as a coverage cancellation, often interrupting an individual's treatment regimen and resulting in significant medical bills.
- *No Change to Coverage.* Sometimes, post-claims underwriting does not result in any action taken against the policyholder.

Real Life Examples Raise Fairness Concerns

Anecdotal accounts have sparked a recent interest in post-claims underwriting in the major medical health insurance market. Fairness issues arise either if an insurer were to cancel policies simply to improve profits, or if confusing rules create an uneven playing field, biased against the individual. Some examples include:

- *Undiagnosed Preexisting Conditions:*
A retiree purchased a series of 6-month short-term insurance policies. Several months after one of these policies went into effect, she went to the doctor regarding a lump that had been behind her ear for about a year. The lump turned out to be cancer, and her insurer canceled her policy on the basis that the lump was preexisting and “an ordinarily prudent person would seek diagnosis or treatment when a lump initially presents itself”⁶ – which was prior to the purchase of her current policy.

Post-Claims Underwriting in the Group Market

Post-claims underwriting can happen in the group market. For example, not all states require insurers to cover certain populations, such as step-children or adopted children. Post-claims underwriting can seek to ascertain a policyholder's status, and cancel or rescind coverage for those found to not qualify for coverage. Also, if a health condition was not disclosed during underwriting and that condition would have resulted in a significant increase, the increase might be imposed retroactively or the coverage might be cancelled or rescinded (for the individual who did not disclose information or for the entire group).

- *Omitted Insurance Application Information:* A mother of three who was covered by a policy purchased on the individual market had to have emergency surgery for a perforated ulcer. After the surgery, her insurer asked for more information about her medical history, revealing a past trip to the ob-gyn for heavy menstrual periods which her doctor had assured her were normal. The insurance company rescinded her policy based on this omission, leaving the family with \$30,000 in surgery bills.⁷
- *Insufficient Underwriting:* A California woman with endometrial cancer received a hysterectomy, which had been preapproved by her insurer. Her insurer rescinded her coverage for not including her previous bout with breast cancer on her application – even though the breast cancer had occurred 11 years prior and the insurance application only asked for her medical history over the past 10 years. She had asked her insurance agent if she needed to include information about her breast cancer, and he told her no. The patient was left responsible for \$160,000 in medical bills.⁸

In response to consumer complaints much like those outlined above, California’s Department of Insurance (CA DOI) has required three major insurers – Blue Cross, Blue Shield and Health Net – to restore health coverage which had been wrongfully rescinded for thousands of Californians.⁹ Millions of dollars in fines against insurers for misconduct have been levied by both CA DOI and the California Department of Managed Care.¹⁰

Varying Regulations and Unknown Enforcement Practices Raises Questions

These examples raise important questions about how post-claims underwriting could be better regulated by the states or the federal government. Little research has been done on the oversight of post-claims underwriting – both understanding the patchwork of state protections and how those protections are enforced. Both federal and state governments have some jurisdiction over insurance company practices related to rescissions.

Federal Regulations: HIPAA

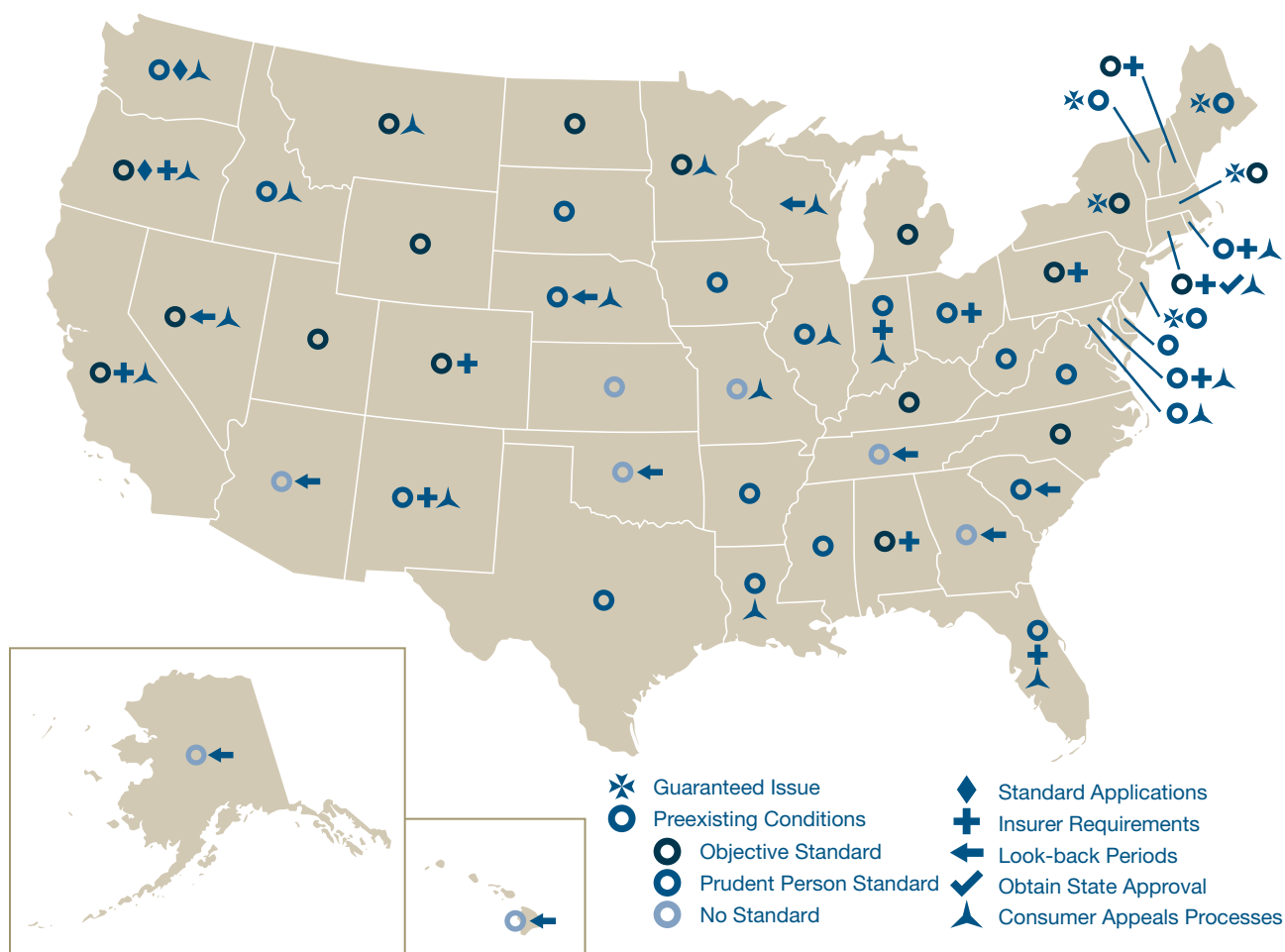
Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), insurers are required to renew health insurance policies on the individual and group markets. This means in “most cases, that employers or individuals who purchase health insurance can renew the coverage regardless of any health conditions of individuals covered under the insurance policy.”¹¹ The exceptions to guaranteed renewability are: non-payment of premiums; “fraud or other intentional misrepresentation”; if the insurer is leaving the market; if an individual or employer moves out of geographic area of the plan; or, in the case of an association policy, if an individual has left the association contracting with the plan.¹²

State Regulations

States maintain primary regulatory jurisdiction over health insurance, including post-claims underwriting. The federal HIPAA protections set a floor in consumer protections, but states are allowed to create stronger regulations, as some states have. The following are several types of state regulations around post-claims underwriting:

General Consumer Protection Regulations

- *Guaranteed Issue:* Some states require that any health insurer accept every applicant. As insurers cannot use medical information to condition their acceptance of applicants, they cannot use medical information to cancel or rescind policies later. Just five states offer this regulation for all individual market policies and all residents. (ME, MA, NJ, NY, VT)¹³ In other states, guaranteed issue may apply only to qualified applicants (e.g., those who are leaving group coverage and thus are HIPAA eligible) or to certain policies offered by designated insurers (often Blue Cross and/or Blue Shield).
- *Preexisting Conditions:* For policies sold in the individual market, there are three ways that states have generally defined a preexisting condition:
 - » Objective Standard: Only conditions for which an individual has received actual medical care qualifies as a preexisting condition. (AL, CA, CO, CT, KY, MA, MI, MN, MT, NV, NH, NY, NC, ND, OR, PA, UT, WY)
 - » Prudent Person Standard: Any condition that a “prudent person” would have sought coverage for. This standard allows medical conditions which have not been diagnosed or fully manifested to qualify as preexisting (such as the first anecdotal example above). (AR, DE, DC, FL, ID, IL, IN, IA, LA, ME, MD, MS, NE, NJ, NM, OH, RI, SC, SD, TX, VT, VA, WA, WV, WI)¹⁴
 - » No Standard: Some states do not define preexisting conditions in law, leaving to insurers to establish and use their own standards. (AK, AZ, GA, HI, KS, MO, OK, TN)¹⁵



Regulations Around the Application and Underwriting Process

- *Standard Applications:* Health insurance applications may be long, complex and hard to fill out, which sometimes leads to errors for which individuals have had policies rescinded or cancelled. Some states have tried to require insurers to simplify their applications, or use a uniform application. For example, Oregon insurers are only allowed to use the Oregon Standard Health Statement form, which is 7 pages long, to underwrite the health status of applicants. While Oregon does not allow information about a person's occupation or hobbies to be included, as can be required in other states, the form does require an extensive medical history going back five years. (OR and WA require uniform applications)¹⁶
- *Insurer Requirements to Complete Medical Underwriting at the Time of Application:* These laws are an attempt to ensure that only those individuals who will be able to keep their coverage receive coverage in the first place. This limits individuals' financial risk of having to pay for medical claims if their insurance policies are rescinded, but may make coverage harder to obtain as well as more expensive. Individuals suspected of fraud would still be subject to rescission or cancellation of their policy under these regulations. (States Which Require Underwriting: CA, CO, CT, FL, IN, MD, NH, NM, OH, PA, RI, WA; States Which Enforce Requirement Without Formal Regulation: AL, NE, OR)¹⁷
- *Look-Back Periods:* Some states limit how far back into an individual's medical history an insurance company can investigate during medical underwriting. This helps protect individuals from being penalized for conditions which have passed. (No individual market look back limit: AK, AZ, DC, GA, HI, KS, MO, NE, NV, OK, SC, TN, WI)¹⁸

Regulating the Process After Post-Claims Underwriting

- *State Rescission Standards:* Law standards for rescissions vary by state. Some states allow "material" omissions or misrepresentations as grounds to cancel, reform, or rescind a policy. This means that if the insurer had known the omitted information regarding a person's health status at the time coverage was issued, the underwriting action would have been different. The applicant's intent may not matter if the standard is material omission. Other states use HIPAA standards, which require proof of fraud or intentional misrepresentation in order for a policy to be rescinded or cancelled. While the federal government has oversight authority to ensure that HIPAA guaranteed renewability regulations are enforced at the state level, the federal agency responsible has not reviewed state laws to ensure they reflect those HIPAA rules.¹⁹
- *Obtain State Approval for Coverage Cancellation or Rescission:* Although just one state currently requires pre-approval of coverage cancellation or rescission. (CT)²⁰
- *Consumer Appeals Processes:* States can provide a government-based appeal process if they have lost coverage and believe it was unlawful, or they can require insurance companies to establish a process to do so. (CA, CT, DC, FL, ID, IL, IN, LA, MD, MN, MO, MT, NE, NV, NM, OR, RI, WA, and WI)²¹

(Endnotes)

- ¹ Waxman, Henry, Opening Statement to U.S. House of Representatives Committee on Oversight and Government Reform Hearing, "Business Practices in the Individual Health Insurance Market: Terminations of Coverage," July 17, 2008.
- ² California Department of Insurance, "Insurance Commissioner Steve Poizner Announces \$15 Million Settlement with Blue Cross Over Rescission Practices," News Release, February 11, 2009.
- ³ Kaiser Family Foundation calculations using data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), 2006. Calculations located in Kaiser Family Foundation, "Health Care Costs: A Primer," March 2009.
- ⁴ Collins, Sara R., et al, "Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families," The Commonwealth Fund, September 2006.
- ⁵ Kaiser Family Foundation, "How Private Health Coverage Works: A Primer, 2008 Update," April 2008.
- ⁶ Appleby, Julie, "People left holding the bag when policies revoked," *USA Today*, December 13, 2007.
- ⁷ Appleby, Julie, "People left holding the bag when policies revoked," *USA Today*, December 13, 2007.
- ⁸ Girion, Lisa, "Anthem Blue Cross Sued Over Rescissions," *Los Angeles Times*, April 17, 2008.
- ⁹ California Department of Insurance, "Insurance Commissioner Steve Poizner Announces \$15 Million Settlement with Blue Cross Over Rescission Practices," News Release, February 11, 2009.
- ¹⁰ Girion, Lisa, "Anthem Blue Cross Agrees to Take Back Clients, Pay \$1 Million Fine" *Los Angeles Times*, February 11, 2009.
- ¹¹ Health Care Financing Administration (now known as the Centers for Medicare and Medicaid Services), "Protecting Your Health Insurance Coverage," Department of Health and Human Services Agency, available at <http://www.cms.hhs.gov/HealthInsReformforConsume/Downloads/protect.pdf>.
- ¹² The Health Insurance Portability and Accountability Act of 1996, Sections 703, 2712, 2742 and 9803.
- ¹³ Kaiser Family Foundation, State Health Facts, www.statehealthfacts.org.
- ¹⁴ Ibid.
- ¹⁵ Ibid.
- ¹⁶ Families USA, "Post-Claims Underwriting Survey," June 2008 Health Policy Memo.
- ¹⁷ Ibid.
- ¹⁸ Kaiser Family Foundation, State Health Facts, www.statehealthfacts.org.
- ¹⁹ Block, Abby L., "Statement on Rescission of Individual Health Insurance Policies," House Committee on Oversight and Government Reform, July 17, 2008.
- ²⁰ Families USA, "Post-Claims Underwriting Survey," June 2008 Health Policy Memo.
- ²¹ Ibid.

Post Claims Underwriting and Rescission Practices

Findings from Texas in the Individual Health Insurance Market

At a June 2009 hearing of the House Energy and Commerce Subcommittee on Oversight and Government Reform, Robin Beaton of Waxahachie, Texas, shared her personal story on post-claims underwriting. Three days before Beaton was scheduled to have a double mastectomy due to an aggressive form of breast cancer, her health insurer informed her that they were putting her coverage on hold for three months while they performed post-claims underwriting. After finding a minor discrepancy in her case regarding a doctor's visit for acne, Beaton's insurer canceled her policy.¹ Beaton was without health coverage and delayed treatment for five months, during which time the tumor tripled in size. Eventually, her health coverage was reinstated after intervention from her Congressman, Joe Barton (R-TX).²

The Beaton case is one of a number of well-publicized reports regarding insurance companies dropping coverage for individuals who had already purchased an insurance policy which has led federal and state policymakers to focus on insurer practices in the individual market. The focus of this debate has been on whether or not insurers have treated such individuals appropriately under existing law and if changes to current law are needed. The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) created a standard called "guaranteed renewability" which is intended to protect policyholders from losing their coverage except in very limited circumstances such as fraud or nonpayment of premiums.

In 45 states, health insurance policies in the individual market are "medically underwritten," meaning that insurance companies review an applicant's medical history and health status to determine whether to offer coverage and at what price. Post-claims underwriting is a process where an insurer re-investigates the individual policyholder's medical history after the policy has been issued, and in particular after claims are submitted.³ The purpose is to ascertain whether the underwriting process missed information that would have caused the insurance company to have changed its initial offer of coverage. Following this investigation, if new information is discovered that would have led the insurer to reject the applicant in the first place, the insurer, might cancel a policy for future claims, or take back the policy, refunding premiums that had been paid and leaving all claims submitted under the policy for the consumer to pay. This second type of action is referred to as rescission.

The practices of post-claims underwriting and rescission have become controversial. The reasons why insurers might rescind a policy lie at the heart of this controversy. An insurer might rescind a policy if it determines the applicant committed fraud – for example, if the applicant knowingly lied about or tried to hide a pre-existing medical condition in order to qualify for a medically underwritten policy that would then cover claims for that condition. Rescission of underwritten coverage in which there is clear and convincing evidence of fraud on the part of the applicant has not generally been very controversial.

However, insurers might also rescind coverage if, during the post-claims investigation, it discovers new material information – that is, information that would have mattered when underwriters were making their original determination. The material information might or might not be related to the claim that triggered the post-claims investigation. For example, at a recent Congressional hearing, a witness testified that her brother’s policy was flagged for post-claims underwriting after he was diagnosed with lymphoma. When the insurer learned the man had failed to disclose gallstones – a condition his doctor never told him he had – his policy was rescinded.⁴

Critics of this practice express concern that applications for health insurance might include vague or confusing questions that make it difficult for applicants to answer accurately and completely. Competitive pressures might also lead some carriers to conduct less thorough (and less expensive) screening of applicants when coverage is first issued, knowing they can rely on post-claims underwriting to avoid incurring losses later, and that this process leaves consumers vulnerable just when they need coverage most.

The insurance industry argues that post-claims underwriting and rescission are necessary to defend against fraud and to hold down costs and keep insurance affordable. At the same time, the insurer has a significant financial interest in rescinding the coverage of high cost cases, leading to what some have said is the insurance industry violating federal, and in some cases, state law.

This issue has gained attention in state legislatures from Connecticut to California, and it has been the focus of Congressional attention. One state, California, has already levied fines against various insurers for violations of state law.⁵ A subcommittee of the House Energy and Commerce Committee has held two hearings since October 2008, including one to discuss the results of a national survey of states regarding insurer rescission practices. That hearing featured testimony from three major insurers which were found to have rescinded 20,000 health insurance policies nationally over the last five years. Under direct questioning from Congressman Nathan Deal (R-GA), who asked insurance executives whether they would commit to limiting all future rescissions to cases involving clear cut fraud, insurers responded that they will continue their existing rescission practices.

To gain a better understanding of state regulations and enforcement of HIPAA around post-claims underwriting and rescission, this case study analyzes how the state of Texas has approached the issue and the implications this has for national health reform. Given the complexity of the issue and the financial incentives in the current system, the best policy solution is to require insurers to offer coverage to anyone regardless of demographics or medical history – a policy called guaranteed issue. Short of that, the Texas case demonstrates that consumers are vulnerable in today’s individual insurance market. Texas state law does not clearly and consistently reflect the federal HIPAA standard, which may create loopholes in consumer protections. As the state relies on consumer complaints to track rescissions in the market, it does not have sufficient data to be sure insurers are following the law. Federal and state regulators should more proactively engage with consumers and insurers to create a more functional marketplace.

Defining Terms

Guaranteed Renewability: HIPAA created the guaranteed renewability protection, which ensures that every health insurance policyholder will have their policy renewed or continued in force. This means that policies cannot be cancelled or rescinded except in cases of fraud, nonpayment of premiums or other conditions related to the availability of coverage and eligibility of the policyholder.

Medical Underwriting: Generally, insurers conduct medical underwriting at the time of application to determine if they will sell an individual a policy. Underwriting is used to determine the applicant's health status, which can be used to determine the premium rate. Coverage may be limited to exclude any care for any pre-existing conditions.

Post-Claims Underwriting: Post-claims underwriting is when an insurer investigates an individual or small group policyholder's medical history after the policy has been issued, and in particular after claims are submitted.

Policy Rescission: Post-claims underwriting may result in a policy being rescinded, or retroactively cancelled policy back to the time it was issued. The insurer must refund all premiums paid, and recoup any claims paid out, which then become the responsibility of the former policyholder.

Policy Cancellation: Alternatively, post-claims underwriting may result in a policy being cancelled. When a policy is cancelled, the individual simply has no health insurance moving forward. The former policyholder does not receive back premiums but is not responsible for repaying any claims already paid out on the policy.

Policy Limitation: If post-claims underwriting finds a pre-existing condition, the insurer may simply limit the policy to exclude care and treatment for that condition moving forward.

Rescissions in Texas

The Beaton case, along with headlines about rescission practices among insurers in California,⁶ prompted Texas policymakers to proactively investigate the issue. State legislators, such as State Senator Eliot Shapleigh (D-SD29), and other stakeholders, such as the Texas Medical Association, proposed new legislation addressing insurer practices on the individual insurance market in the 81st Texas legislative session, which ended in early June 2009.⁷

The Texas Department of Insurance (TDI) response to the Congressional survey also helped to highlight concerns for state policymakers. As part of that response, Texas surveyed companies with at least 250 policies in effect in the state's individual market to determine the number of policies they had rescinded in the past five years. That data showed 6,377 policies between 2003 and 2007 were rescinded in the state.

Table 1. Rescission Rates in the Texas Individual Health Insurance Market⁸

	Total Number of Policies in Force	Total Number of Rescissions	Percent of Total Policies Rescinded
2003	451,148	880	0.2%
2004	467,238	927	0.2%
2005	479,162	1,326	0.3%
2006	528,192	1,700	0.3%
2007	506,791	1,544	0.3%

Source: Author calculations based on Texas Department of Insurance, Office of the Commissioner data provided to Congressman Henry A. Waxman on October 31, 2008

As a percent of all policies in effect in a single year, the rate of rescission is less than 1 percent. However, this likely understates the effective rate of rescission.

- 1) ***New Policies.*** Rescissions are more likely to occur among new policies (particularly in the first two years the policy is in effect). Dividing the number of rescissions by the total number of all policies in effect, including policies in force longer than 1 to 2 years, creates the impression of a lower rescission rate.
- 2) ***Expensive Claims.*** There is reason to believe that insurers focus rescissions on policies involving the most expensive, or potentially expensive claims.⁹ If so, then it would be more accurate to consider the rate of rescission among the smaller universe of first year policyholders who make claims for high cost conditions. With only 20 percent of individuals accounting for 80 percent of all health care expenditures, the proportion of policyholders likely to be targeted for rescission could be substantially smaller than the whole market.

Texas Regulations

The laws and regulations in Texas are inconsistent with federal standards in guiding insurer underwriting and rescission practices. This section looks at the differences in federal and Texas law, as well as the impact of the Texas courts.

Federal Standard

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) created a standard for every health insurance policy. Known as “guaranteed renewability,” this law means that an insurer can discontinue a policy only in limited circumstances. In relevant part:

Except as provided in this section, a health insurance issuer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual.¹⁰

This law states that not only must coverage be reissued when it comes up for renewal, but that insurers cannot cancel an existing policy, except under limited circumstances. There are five exceptions to guaranteed renewability, including if policyholders do not pay their premiums, if policyholders move out of the geographic area served by the policy, if the policy is discontinued for all policyholders, or if policyholder leaves an association through which they had purchased groups coverage. The final exception is fraud – the exception most closely tied to rescissions.¹¹

The fraud exception is designed to protect both insurers and consumers. Insurers are protected from consumers who intentionally misrepresent their medical history and health status in order to obtain health insurance. This prevents individuals from waiting until they need coverage to purchase it, which drives up costs of health insurance for everyone. Consumers are protected from losing coverage that they have sought and paid for in good faith.

Texas Standard

There is a lack of clarity in Texas statutory law regarding the HIPAA standard. One section of the Texas Insurance Code clearly reflects the HIPAA standard:

[Health insurance shall be renewed or continued in force unless] the policyholder has performed an act or practice that constitutes fraud, or has made an intentional misrepresentation of material fact, relating in any way to the policy, including claims for benefits under the policy . . .¹²

Another section of Texas Insurance Code may be interpreted as inconsistent with HIPAA. In relevant part, the law specifically says:

After the second anniversary of the date this policy is issued, a misstatement, other than a fraudulent misstatement, made by the applicant in the application for the policy may not be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) beginning after that anniversary.¹³

This may be interpreted as creating a “contestability period.” This would mean that insurers are not limited to rescinding coverage only in the event of fraud as outlined in HIPAA and elsewhere in Texas state law, in the first two years of coverage.¹⁴ This is when many individual are believed to be more likely to face a rescission.¹⁵

Despite this contestability period, common law standards of the Texas Supreme Court require insurers to prove a standard of deceptive intent (or fraud) of the insured in order to rescind a policy based upon misrepresentation in the application for coverage.¹⁶ This standard has been applied to cases where coverage was in effect for fewer than two years.¹⁷ Specifically, an insurer must prove deceptive intent in the following:

- “the making of the representation;
- “the falsity of the representation;
- “reliance on the false representation by the insurer;
- “the intent to deceive on the part of the insured in making the false representation; and
- “the materiality of the representation.”¹⁸

There is thus a lack of clarity between state law which incorporates the HIPAA fraud protection, the state law which may provide an exemption from that protection in the first two years of coverage, and Texas common law.

Texas Regulatory Enforcement

TDI is responsible for a number of activities related to enforcing state insurance law, including:

- Consumer Education and Outreach;
- Complaint Tracking and Response; and,
- Market Conduct Review.

Consumer Education and Outreach

Texas policymakers have expressed concern that consumers may not know to contact the Department if their health insurance claim has been denied or if their policy has been rescinded.¹⁹ The system today requires individuals to be proactive in learning their rights and using them.

- Information about consumer rights and responsibilities are available through a TDI website, including how consumers can file complaints, although the web site does not appear to provide specific consumer information about rescission. Consumers can reach TDI with complaints and grievances via a general hotline, email, fax and an online form. TDI has one complaint contact system for consumers of health and other types of insurance.
- By law, insurers are required to notify policyholders whose coverage has been cancelled that they have the right to appeal. However, TDI does not verify if this is taking place.²⁰ To the extent there is a notification of rights, consumers are receiving the information at what is likely to be a difficult time, as most facing rescission have been recently diagnosed with a serious illness.²¹

Complaint Tracking and Response

TDI relies on consumers contacting them with complaints to track what is happening in the market. The Department does not routinely collect data counts of health insurance policies or counts of rescissions. This passive approach seems to be consistent with the practice of most states. More than a third of states were unable to provide Congress with a complete list of insurers selling individual health insurance policies in their state.²² Just 10 states reported that they knew the number of individual health insurance policies in force in their states.²³ Only four states reported the number of rescissions in their individual markets, and there was no indication that any state requires insurers to regularly report statistics on the number or nature of post-claims underwriting investigations or rescissions.²⁴

The Department's complaint inquiry system does collect consumer rescission complaint information. After consumers contact TDI, staff members investigate the concern to determine whether the complaint is justified or unjustified. For rescissions, the investigation seeks to determine if the policyholder intentionally misrepresented his or her medical background on their insurance application. According to TDI staff, intent is sometimes difficult to ascertain, making the issues in a particular case difficult for the agency to resolve. At any point, consumers have the right to file a lawsuit for any reason.²⁵

However, from 2003 to 2007, only seven of the 6,377 policyholders known to have had their coverage rescinded contacted TDI with a complaint--and only one of those complaints was determined to be justified.²⁶ This suggests that the Texas consumer complaint database is not a good indicator of the size or scope of the rescission issue in the state.

Market Conduct Reviews

In market conduct reviews, TDI examines insurance companies to ensure that they are treating policyholders and claimants equitably and that they are in compliance with statutes and regulations. The Department has never conducted a market conduct exam focused on the rescission issue, but reports that in any exam it would “utilize all complaint data, including rescissions, in determining a company’s compliance with the law.”²⁷ Regulators have discretion in deciding when to conduct a review. Some occurrences which may lead regulators to conduct a review include:

- An increase in the number of complaints for the entire market compared to a previous year;
- An unusual volume of complaints from a specific insurance agency;
- Various financial indicators; and
- The grievousness of the complaint may trigger a review of the specific insurer.²⁸

There are no triggers in place that would mandate a market conduct review. The exception is with health maintenance organizations (HMOs) which must go through a mandated market conduct review every three years.²⁹ Market conduct reviews are one possible tool that regulators such as TDI could use to delve further into industry post-claims underwriting and rescission practices, although they have not yet exercised that tool.

Role of the Federal Regulators in Texas

While HIPAA gives the federal government oversight of state insurance regulatory practices to ensure enforcement of HIPAA protections, there is little evidence that the federal government has exercised that authority. Texas policymakers were unaware of any federal oversight or interaction related to the state’s health insurance regulations.³⁰ This is consistent with statements by federal officials.

At a 2008 Congressional hearing, Abby Block, Director of the Center for Drug and Health Plan Choice at the Center for Medicare and Medicaid Services testified that states have the “primary responsibility” for enforcing HIPAA.³¹ Block also testified that “CMS can only act if it determines that a State fails to substantially enforce the requirement,” but that CMS believed that “the vast majority of States, like the State of California, in fact are enforcing” appropriately. According to Block, CMS had yet to exercise its oversight authority. It is unclear what actions most states have taken to “substantially enforce the requirement,” particularly states such as Texas which continue to have statutes in direct conflict with HIPAA standards. TDI has not taken any enforcement actions against insurers in regards to improper coverage rescission or cancellations.

Looking Ahead to Change the System – Recent Legislative Work on Rescission and Enforcement

Texas legislators and consumer groups are proactively proposing and advocating for changes to state law to strengthen and clarify state regulations in the individual insurance market. In the most recent legislative session alone, six stand-alone bills were proposed, as outlined in Table 2. None of the stand-alone bills passed, but several provisions of one of those bills were attached as an amendment to

another piece of legislation and were adopted. Some of these laws were modeled after recent efforts in California.³² Additionally, the Texas Association of Health Plans and the Texas Association of Life and Health Insurers supported several of these bills.³³

Table 2. *Legislation Pertaining to Health Insurance Rescission Proposed in the 81st Legislature – Texas*

Legislation	Description	Status
Amendment F4 – SB 1007	<p>This amendment contained the following provisions:</p> <ul style="list-style-type: none"> • Prohibits insurers from setting cancellation quotas and cancellation performance standards or paying employees bonuses for cancelling policies. • Requires insurers to provide individuals notice of the insurer’s intent 60 days before rescinding or canceling coverage, as well as the consumer’s right to file a complaint with the department of insurance if individuals believe cancellation is inappropriate. 	Adopted
HB 1748 / SB 1611	<p>This legislation contained the following provisions:</p> <ul style="list-style-type: none"> • Prohibits insurers from setting cancellation quotas and cancellation performance standards or paying employees bonuses for cancelling policies. • Provides individuals the right to an independent review and a decision within 20 days of their insurer’s decision to cancel or rescind their coverage, paid for by the insurer. • Requires insurers to provide individuals notice of the insurer’s intent to rescind or cancel coverage, as well as the consumer’s right to appeal the rescission within 45 days to an independent review organization. • Protects physicians from insurers recouping amounts paid on medical claims under a cancelled benefit plan, but does not protect consumers from this practice. • Limits look-back period, or time period allowed for review of medical history for a pre-existing condition, to 18 months prior to the date of application for coverage. 	<p>HB 1748 – Pending in House Insurance Committee</p> <p>SB 1611 – Referred to Senate State Affairs Committee</p>

Table 2. (continued) *Legislation Pertaining to Health Insurance Rescission Proposed in the 81st Legislature – Texas*

Legislation	Description	Status
SB 1257 / HB 2750	<p>This legislation contained the same provisions as HB 1748/SB 1611, as well as the following additional provisions:</p> <ul style="list-style-type: none"> • Requires state authorized insurers to submit reports of rescission rates and reason for rescissions to the Department of Insurance; these reports will be posted on the department’s website. • Requires the Department of Insurance to provide a complaint form on the department’s website for individuals to report believed unlawful rescission practices, as well as a toll-free telephone hotline for consumers to receive information and technical assistance on issues pertaining to rescission. 	<p>SB 1257 – Pending in Senate State Affairs Committee</p> <p>HB 2750 – Pending in House Insurance Committee</p>
SB 206	<p>This legislation would have contained the following provisions:</p> <ul style="list-style-type: none"> • Requires state authorized insurers to submit reports of rescission rates and reason for rescissions to the Department of Insurance; these reports will be posted on the department’s website. • Requires the Department of Insurance to provide a complaint form on the department’s website for individuals to report believed unlawful rescission practices, as well as a toll-free telephone hotline for consumers to receive information and technical assistance on issues pertaining to rescission. 	<p>Referred to House Insurance Committee</p>
SB 207	<p>This legislation would have prohibited insurers from setting cancellation quotas and cancellation performance standards or paying employees bonuses for cancelling policies.</p>	<p>Referred to House Insurance Committee</p>
SB 303	<p>This legislation would have required uniform health insurance application question to collect medical history information, and provided time limits to the approval, cancellation or rescission of health benefit plan coverage.</p>	<p>Referred to Senate State Affairs Committee</p>

Table 2. (continued) *Legislation Pertaining to Health Insurance Rescission Proposed in the 81st Legislature – Texas*

Legislation	Description	Status
SB 350	<p>This legislation contained the following provisions:</p> <ul style="list-style-type: none"> • Insurance agents would become liable for filling out applications accurately and completely; • If multiple individuals are covered under a single policy and one person has their coverage rescinded, the remaining individuals are entitled to a new offer of coverage without a preexisting condition exclusion period. 	Referred to House Insurance Committee

Source: Texas Legislature Online.

The Texas Medical Association supported the bills described above with the goal of increasing transparency for policyholders in understanding their coverage and their insurers’ cancellation practices. Stacey Pogue, a policy analyst for the Center for Public Priorities in Texas says, “Consumers have a responsibility to fill out health insurance applications completely and accurately...But because rescission can have such a profound effect on a policyholders’ health status and their ability to access care, health insurance companies should also be held accountable to ensure that rescissions are rare and justified.”³⁴ Since the 81st legislative session ended recently, concrete plans on next steps to pursue these policy changes have not developed. Yet it is probable that Senator Shapleigh and others will re-file their bills in the next legislative session.³⁵

Although the Texas Legislature will likely have a special legislative session this summer, these bills will not be re-introduced at that time.³⁶ The focus of the special legislative session will be on reinstating the Texas Department of Insurance and other state agencies, which were not reinstated due to a sunset law.³⁷

Findings from Texas and Implications for National Health Reform

Texas offers several lessons for national health reform. Given the challenges in the current health insurance system, the goal to have guaranteed issue will help eliminate much of the confusion caused by post-claims underwriting. In the event health reform does take these steps, the Texas lessons will continue to be valuable because the existing system:

- Will continue for some period as the transition to the new system takes place. Policymakers may want to consider what, if anything, they may want to do to better oversee the individual market in the immediate term.
- Shows the difficulty in understanding whether regulations are having the intended effect in a market if regulators do not have sufficient information about what is happening in that market. Under any new system of health insurance regulation, several steps could be taken that would create greater stability for families purchasing insurance.

The following table outlines the specific case study findings from Texas in each of the areas of investigation, as well as the lessons those findings provide for national health reform efforts.

Table 3. *The Findings from Texas and Lessons for National Reform*

	Finding from Texas	Lesson for National Reform
Federal and State Regulatory Standards	State laws do not clearly and consistently reflect federal standards.	Health insurance regulations must be clear and consistent, so that they can be easily explained to consumers, enforced by regulators and followed by insurance companies.
Consumer Education and Outreach	Consumer outreach and education is limited to passive websites and notices are required only after coverage has been lost.	Insurance regulators should set standards for insurers and brokers to provide consumers with clear information on consumer rights and responsibilities at the time of application, when coverage is issued, when coverage is being investigated, and when coverage is being cancelled. Insurance regulators should also provide this information to consumers.
Complaint Tracking and Response	Forms of insurance market tracking which rely on consumer complaints may not provide complete information for regulators to ensure laws are enforced. Texas has a limited understanding of what is happening in the insurance market.	In addition to robust consumer complaint systems, regulators must proactively collect information on the state of the market. Insurers could be required to regularly report data on covered lives, rescissions and other activities.

Table 3. (continued) *The Findings from Texas and Lessons for National Reform*

	Finding from Texas	Lesson for National Reform
Market Conduct Reviews	Texas has not conducted market conduct reviews focused on the rescission issue. However, the discrepancy between the number of policy rescissions reported by insurance companies and the number of consumer complaints shows that the reliance on consumer complaint databases to identify market conduct may be insufficient.	Standards are needed to trigger market conduct reviews when there is credible information that an insurer may not be following federal or state rules. Periodic audits should also be used to ‘spot check’ compliance with rules. Federal government must take a more proactive role in enforcing rules.
Role of Federal Regulators	Federal regulators have not had any contact with Texas regulators on these issues. Federal regulators report states are adequately enforcing HIPAA protections, despite clear examples to the contrary. ³⁸	Federal regulators will need to be more active to ensure that all states are adopting and enforcing national health insurance regulatory standards. State laws should be reviewed to ensure all sections are in complete compliance with federal standards. State and federal regulators should work together to ensure those laws are then enforced.

Methodology

Texas was selected for this case study on the basis of a series of preliminary interviews with leading policymakers and advocates on post-claims underwriting at the state and federal level. While Texas appears to be typical in terms of existing state laws and regulatory enforcement around this issue, the state is one of a few where policymakers are actively seeking to change those state laws to strengthen market protections and enforcement. A forthcoming report will include the Texas case study as well as case studies of California, Connecticut and Florida. That report will offer an overview of the lessons of state regulations and enforcement around post-claims underwriting and rescissions for national reform efforts.

The information presented in this case study was collected primarily through telephone interviews with representatives from the Texas Department of Insurance, the office of State Senator Shapleigh, the Texas Medical Association, and the Center for Public Policy Priorities. Primary source material included Texas state law, Texas case law, Texas legislative summaries and the Texas Department of Insurance’s letter responding to the inquiry from Congressman Waxman.

About the Paper

The Robert Wood Johnson Foundation is funding research to promote understanding of post-claims underwriting in insurance markets across America, which could then lead to improved state and federal laws to protect both consumers and insurers from fraud and unlawful actions. This paper is the second release in a series of papers on this topic. The first, a Primer on Post-Claims Underwriting explored what is known and unknown about post-claims underwriting, and state and federal insurance regulations around these issues. The third and final paper in the series will be released soon summarizing the findings and policy recommendations from four state case studies on post-claims underwriting and rescissions.

About the Authors

This report was prepared by Harbage Consulting, a Washington DC-based health policy consultancy. Peter Harbage is the president, with more than 17 years of experience in federal and state health care policy. Hilary Haycock is a Director at Harbage Consulting. Meredith King Ledford, formerly with the Center for American Progress, is one of the report's three co-authors and an advisor to Harbage Consulting.

Notes:

¹ Beaton, Robin, Testimony before the U.S. House of Representatives Energy and Commerce Committee Subcommittee on Oversight and Investigations, June 16, 2009. Available at

http://energycommerce.house.gov/index.php?option=com_content&view=article&id=1671:energy-and-commerce-subcommittee-hearing-on-terminations-of-individual-health-policies-by-insurance-companies-&catid=133:subcommittee-on-oversight-and-investigations&Itemid=73.

² See Jarvis, Jan. "Bills would protect patients from canceled health insurance" *Fort Worth Star Telegram*, 11 April 2009 and Anna M. Tinsley, "Breast cancer patient who lost health policy inspires legislation," *Fort Worth Star Telegram*, 29 September 2008.

³ Harbage, Peter, *Primer on Post-Claims Underwriting*, Robert Wood Johnson Foundation, 2009.

⁴ Raddatz, Peggy M., Testimony Before the U.S. House of Representatives Energy and Commerce Committee Subcommittee on Oversight and Investigations, June 16, 2009. Available at

http://energycommerce.house.gov/Press_111/20090727/02%20Testimony%20of%20Peggy%20Raddatz.pdf.

⁵ See for example, California Department of Managed Health Care News Release, "Department of Managed Health Care Fines Blue Cross of California for Illegally Rescinding Health Insurance Policies," March 2007. Available at

<http://www.hmohelp.ca.gov/library/reports/news/prbccpcsurvey.pdf>.

⁶ See Girion, Lisa, "Garamendi to Probe Blue Cross' Practices," *The Los Angeles Times*, March 20, 2006 and "Former Members to Sue Blue Cross," *Los Angeles Times*, March 28, 2006. Available at http://theenvelope.latimes.com/la-fi-insure200628mar28_0,205423.story.

⁷ Jasti, Sushma, Legislative Analyst, Office of Senator Eliot Shapleigh, Texas Senate. Phone Interview. June 24, 2009. Johnson, Richard. Texas Medical Association. Phone Interview. 3 June 2009. Also Johnson, Richard. Texas Medical Association. Phone Interview. 3 June 2009.

⁸ Ibid.

⁹ Pollitz, Karen, Statement to the Committee on Energy and Commerce Subcommittee on Oversight and Investigations, June 16, 2009.

¹⁰ Public Health Service Act § 2742(a)

¹¹ The Health Insurance Portability and Accountability Act of 1996, Public Health Services Act, Section 2742.

¹² (28 TAC § 3.3038(c)(2). Pollitz, Karen, Statement to the Committee on Energy and Commerce Subcommittee on Oversight and Investigations, June 16, 2009.

-
- ¹³ Texas Department of Insurance Letter to Congressman Henry Waxman, October 31, 2008.
- ¹⁴ Pollitz, Karen, Statement to the Committee on Energy and Commerce Subcommittee on Oversight and Investigations, June 16, 2009.
- ¹⁵ Pollitz, Karen, Statement to the Committee on Energy and Commerce Subcommittee on Oversight and Investigations, June 16, 2009.
- ¹⁶ See *Union Bankers Ins. Co. v. Shelton*, 889 S.W.2d 278, 281-282 (Tex. 1994); *Mayes v. Mass. Mut. Life Ins. Co.*, 608 S.W.2d 612, 616 (Tex. 1980); *Allen v. American Nat'l Ins. Co.*, 380 S.W.2d 604, 607-08 (Tex. 1964); *Clark V. Nat'l Life and Accident Ins. Co.*, 200 S.W. 45, 46 (Tex. 1888).
- ¹⁷ See for example *Hinna v. Blue Cross*, NO. 4:06-CV-810-A (Tex. 2007).
- ¹⁸ Texas Department of Insurance Letter to Congressman Henry Waxman, October 31, 2008.
- ¹⁹ Sushma, Legislative Analyst, Office of Senator Eliot Shapleigh, Texas Senate. Phone Interview. June 24, 2009.
- ²⁰ Phone Interview with staff at the Texas Department of Insurance, June 11, 2009.
- ²¹ Pollitz, Karen, Statement to the Committee on Energy and Commerce Subcommittee on Oversight and Investigations, June 16, 2009.
- ²² House of Representatives Committee on Energy and Commerce, "Supplemental Information Regarding the Individual Health Insurance Market," June 16, 2009.
- ²³ House of Representatives Committee on Energy and Commerce, "Supplemental Information Regarding the Individual Health Insurance Market," June 16, 2009.
- ²⁴ House of Representatives Committee on Energy and Commerce, "Supplemental Information Regarding the Individual Health Insurance Market," June 16, 2009.
- ²⁵ Daniel, Katrina, Associate Commissioner for the Life, Health & Licensing Program and staff, Texas Department of Insurance. Phone Interview. June 11, 2009.
- ²⁶ Letter to Congressman Henry A. Waxman regarding the Individual Health Insurance Market from the Texas Department of Insurance, Office of the Commissioner, October 31, 2008.
- ²⁷ Letter to Congressman Henry A. Waxman regarding the Individual Health Insurance Market from the Texas Department of Insurance, Office of the Commissioner, October 31, 2008.
- ²⁸ Phone Interview with staff at the Texas Department of Insurance, June 11, 2009.
- ²⁹ Phone Interview with staff at the Texas Department of Insurance, June 11, 2009.
- ³⁰ Phone Interview with Stacey Pogue at the Center for Public Policy Priorities.
- ³¹ Statement of Abby L. Block, Director, Center for Drug and Health Plan Choice, Centers for Medicare and Medicaid Services, on Rescission of Individual Health Insurance Policies Before the House Committee on Oversight and Government Reform.
- ³² Sushma, Legislative Analyst, Office of Senator Eliot Shapleigh, Texas Senate. Phone Interview. June 24, 2009.
- ³³ *Ibid.*
- ³⁴ Pogue, Stacey, Testimony, "B206 and 207 Increase Consumer Protections Around Health Insurance and Policy Rescissions," before the Texas Senate State Affairs Committee, 81st Legislature, April 27, 2009.
- ³⁵ Sushma, Legislative Analyst, Office of Senator Eliot Shapleigh, Texas Senate. Phone Interview. June 24, 2009.
- ³⁶ *Ibid.*
- ³⁷ *Ibid.*
- ³⁸ Examples of this include statements by insurance industry representatives at the June 2009 Congressional hearing regarding the industry's practice of rescinding policies even without proof of fraud. Available at http://energycommerce.house.gov/index.php?option=com_content&view=article&id=1671:energy-and-commerce-subcommittee-hearing-on-terminations-of-individual-health-policies-by-insurance-companies-&catid=133:subcommittee-on-oversight-and-investigations&Itemid=73.