Testimony before the House Committee on Oversight and Government Reform

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Chairman Waxman, Ranking Member Davis and Members of the Committee, for the record my name is Kevin Lembo. I am the Healthcare Advocate for the State of Connecticut. The Office of the Healthcare Advocate is an independent state agency that advocates for and represents consumers in their dealings with the health insurance industry. On behalf of the growing number of Americans who find themselves trying to get and keep coverage in the individual health insurance market, thank you for your willingness to shed light on the problem of post-claims underwriting abuse and insurance policy rescissions.

The problem of post-claims underwriting abuse and policy rescissions appears to be growing. The result of this process, and a particularly egregious result, is the unjust rescission, cancellation or limitation of a health insurance contract after someone is diagnosed with an illness and faced with expensive medical care.

It is important to begin with a clear definition of the problem: I am talking about a health insurance transaction where inadequate underwriting occurs upon a consumer's application for insurance, and an insurance company later mines for a justification in the medical record later for a rationale to rescind the policy. The mining is especially aggressive if an expensive claim stream starts coming through the insurance company's door for payment.

In Connecticut, we were fortunate and identified this problem in our market beginning in 2003. My office, the office of our Attorney General Richard Blumenthal and our state Insurance Department saw a jump in complaints from consumers whose policies were rescinded or limited in some other way. They were sick, and didn't understand why their coverage was taken away or limited. Ultimately, a coordinated and successful effort by our offices was undertaken to fix the problem through legislation.

Connecticut's law, *An Act Concerning Postclaims Underwriting* (Conn. Gen. State. § 38a-477b), is the product of three years of work at the legislature to protect consumers from unfair health insurance rescissions, cancellations or limitations of their individual policies. Under the Connecticut Public Act, insurers now need the approval of the Connecticut Insurance Department before they can rescind, cancel or limit a policy in any manner.

I want to be clear at the outset that this public policy debate is not about consumers who intentionally misrepresent their health status. That is a red herring that is utilized as a distraction for those who rather we not have this conversation. Further, we could spend a day arguing about what motivates the desperate, albeit infrequent, action to lie on an

application. Instead, I am focusing on those whose policies were unjustifiably rescinded, cancelled or limited by a carrier to avoid paying claims.

In Connecticut, a company denied claims for a resident named *Maria* when she was diagnosed with non-Hodgkin's lymphoma in 2005. The insurer said *Maria* should have sought treatment and found out the diagnosis sooner - in other words, before seeking a policy.

Once the company started receiving her medical claims, it found out she had gone to the doctor for what she thought was a pinched nerve. She also told the doctor she'd been feeling a little tired. *Maria* said she wasn't concerned about the way she was feeling because she had been working particularly hard. Tests were done at that time to determine whether there were other issues. These tests did not yield significant results, and were not tests for cancer. The company denied payment for subsequent, cancer-related bills, saying that *Maria* had this condition before she bought her policy and should have sought treatment. *Maria* ultimately died from her illness.

In another case, a company rejected claims of a 34-year-old woman diagnosed with Hodgkin's lymphoma one month after her policy began. Why? In a medical visit after enrolling, she recalled mild shortness of breath while exercising six months before the visit. The insurer said the symptom constituted a pre-existing condition and should have caused her to seek treatment before enrollment. It did not matter to the carrier that the shortness of breath was completely unrelated to the lymphoma and could have been caused by simple over-exertion during exercise.

A young man, *Frank*, was taken by surprise when his insurance was rescinded because his insurer alleged that he omitted material information from his insurance application. When *Frank* applied for coverage, he disclosed that he had occasional headaches. After he applied, the carrier obtained all of *Frank's* medical records – theoretically for medical underwriting – and then wrote him a policy. Several months after getting his policy, *Frank* went for a routine eye exam and was referred to a neurologist by his eye doctor. The neurologist diagnosed *Frank* with Multiple Sclerosis. Immediately following that diagnosis, the carrier rescinded the policy stating, in effect, that he should have known his headaches would have led to the diagnosis of MS. The carrier stuck to its position even after receiving a letter form *Frank's* doctor saying there would have been no reason to suspect MS since *Frank* was an otherwise healthy young man with a normal examination. *Frank* was now responsible for more than $30,000 in care that he could not afford. *Frank's* condition rapidly deteriorated, forcing him to end his employment and seek public insurance and assistance.

These are the kinds of people who are impacted by post-claims underwriting abuses, and that impact is medically and financially devastating.

Unfortunately, while State Insurance Departments can often intercede in these cases through market conduct examinations and under their existing laws against unfair insurance practices, there is little that they can do as regulators to make it right for these consumers. As state regulatory agencies, they can fix problems going forward – making it safe for future consumers, but are limited in what they can do for these now, relatively

uninsurable consumers who are back in the marketplace with new pre-existing conditions that they didn't have before, and a policy rescission in their underwriting history.

States need to stop this problem on the front-end with good, clear law that prohibits these abuses and forces companies to seek permission before rescinding, canceling or limiting an existing insurance contract. The practice must be stopped on the front-end, because the clean-up is almost impossible.

In Connecticut, the Insurance Department recently concluded a very long and deep investigation of the Assurant Companies, Time Insurance Company (formerly Fortis) and John Alden Insurance Company, that resulted in a state record fine of $2.1 million and more than $900k in restitution. The Department did all they could, but the damage to the individuals had been done.

In its review, the Department found that the companies performed unfair or deceptive acts related to denial of payment for claims secondary to the insurance company's false position that the consumers had a pre-existing condition. In addition, the companies were found to have violated various sections of Connecticut's Unfair Insurance Practices laws (Conn. Gen. Stat. § 38a-816) including: failing to process claims fairly or in a timely manner as required by statute; failing to affirm or validate coverage; failing to provide an explanation for claim denials; and, failing to pay interest on late claim payments as required by law.

Although the companies admitted no wrong-doing, they agreed to pay the fine and restitution. In addition, the companies paid for the full cost of the market conduct investigation, and agreed to comply with a corrective action plan that includes annual market conduct exams over the next four years.

In April and May of this year, as part of a larger survey on state health insurance regulation, FamiliesUSA surveyed all state insurance departments regarding laws to prohibit insurers from limiting or rescinding health insurance policies after issuance. FamiliesUSA planned to communicate with the committee directly about the results of their survey, but thought it important to share a few points from their work.

FamiliesUSA put a number of questions to insurance departments across the country, including:

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

    a. Thirteen states replied yes: CA, CO, CT, FL, IN, MD, NH, NM, OH, PA, RI, VA, and WA.
    b. Three (AL, NE and OR) replied that while their insurance laws are not explicit, they do enforce such a policy.
    c. States with guaranteed issue and community or modified-community rating (ME, MA, NJ, NY, and VT) generally replied that this question does not apply to them.
    d. The remaining 29 states replied that they have no such requirement.

2. 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?

    a. Only Connecticut presently has such a requirement.

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

    a. Nineteen 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, VT, WA, and WI).
    b. An additional seven states responded that though it is not through a formal appeals process, they investigate consumer complaints if coverage is rescinded (KY, MI, ND, SC, SD, TN, and TX).
    c. In twenty states, consumers do not have appeal rights if their coverage is rescinded.

Mr. Chairman, it is my opinion, and that of many of my colleagues, that our states must move rapidly to address the issue of post-claims underwriting abuses. It is my hope that legislatures across the country, with your encouragement, will take the following steps to protect consumers and ensure a level playing field in the individual health insurance marketplace:

1. Creation and adoption of a state or national uniform application for individual health insurance. This standard application should be created by advocates, academics, and the industry together. It must be clear, and designed to elicit necessary information, but not so heavy with jargon or medical terminology, that the average consumer does not understand the questions or makes errors.
2. States must define “medical underwriting” and be clear that a review of the application alone is not sufficient. Further, states must require that underwriting be complete, and all outstanding questions answered, before a policy is written.
3. Creation and adoption of laws to stop post-claims underwriting abuses, and provide greater limitations on a company’s ability to rescind or limit a policy without some finding of fact and approval of the state insurance regulator.

Since passage of our Connecticut post-claims underwriting law, complaints from consumers have dropped to a handful, and the Insurance Department had received no requests to modify or rescind a policy. I think this speaks to the effect of good law and I would encourage my colleagues in other states to join us in ending this practice.

Thank you.