Testimony on

Ensuring Fair and Appropriate Practices in Individual Market Rescissions

by

Stephanie Kanwit
Special Counsel
America's Health Insurance Plans

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I. Introduction

Mr. Chairman and members of the Committee, I am Stephanie Kanwit, Special Counsel for America's Health Insurance Plans (AHIP), which is the national association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. AHIP's members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

We appreciate this opportunity to testify on issues affecting consumers who purchase health insurance coverage in the individual market, specifically in the very rare case where an insurance policy is withdrawn or "rescinded." We commend the Committee for examining the implications of these issues both for consumers and for the health insurance marketplace.

Our testimony today will focus on proposals AHIP has endorsed for reforming the individual health insurance market through a new strategy that calls for shared responsibility between the public and private sectors. Those proposals include a plan to ensure that no one purchasing coverage through the individual market falls through the cracks, as well as new initiatives designed to give consumers peace of mind about their individual health care coverage. We hope those initiatives will be of interest to the Committee, as they include solutions that directly address the issue of ensuring fair and appropriate practices for rescissions as well as preexisting conditions.

We have worked to ensure that no one falls through the cracks of the U.S. health care system, while recognizing that both the private sector and public programs have a role to play in meeting this challenge. For tens of millions of Americans, the need to repair the health care safety net is a deeply personal issue requiring bold solutions that can be implemented in a timely fashion. We recognize that the current system has shortcomings and we are committed to working with members of Congress to advance meaningful reforms that provide affordable coverage options for all Americans.

Other issues we address in our testimony include survey findings about the current state of the individual health insurance market and research findings on the unintended consequences of enacting certain health insurance reforms in the absence of universal coverage. These findings

provide important insights into the strengths of the current system and lessons learned from state reform initiatives over the past 15 years.

II. Proposed Solutions for Those in the Individual Market

AHIP believes that all Americans should have access to health care coverage, and to that end our Board of Directors has put forth a comprehensive plan to expand access to coverage, including the "uninsurable" and those who can not afford coverage.

To address concerns about the individual market, our Board has endorsed a proposal to ensure that no one falls through the cracks. We offer one strategy for states that are not ready to achieve universal coverage and another strategy for states that establish a requirement for universal participation. We also are proposing new initiatives to give consumers peace of mind about individual health care coverage. As illustrated in the following table, our proposal includes new guarantee issue coverage options, premium caps and subsidies to promote affordable coverage, new consumer protections with respect to both rescissions and preexisting conditions, and new responsibilities for health insurance plans.

The Difference Our Proposal Will Make

New Coverage Options	▪ New program for high-risk individuals ▪ GI coverage for those declined by new program
Premium Rates Capped	▪ New program premiums capped at 150% ▪ GI premiums limited to max of 150%
Premium Subsidies	▪ Sliding-scale subsidies based on income, up to 400% FPL
Insurer Responsibilities	▪ Assist with the application process ▪ GI and assume losses above 150%
Limits on Pre-ex Exclusions	▪ One-time open enrollment with no pre-ex ▪ Third party review for pre-ex decisions
Rescission Protections	▪ Rescinded individuals eligible for new program ▪ Third party review for rescission decisions

A critical element of our proposal provides that health plans should provide consumers with access to an independent, *third-party review process* – established by state legislation – to resolve disputes involving medical issues. That process generally would have state regulators screening requests to determine eligibility for review, would specify timeframes for completing the review (with expedited review available for emergency situations), and would require exhaustion of internal appeal processes before initiating the third-party review as well as exhaustion of third-party review before initiation of litigation. The review panel would consist of (at least) one medical professional and one attorney. Any external review decision favorable to the consumer would be *binding on the health plan.*

State Guarantee Access Plans (GAPs)

AHIP's proposal also would create a new safety net for health care consumers. Specifically, if an individual is unable to purchase individual coverage, or has pre-existing medical conditions, then those individuals with high medical costs would still be eligible for coverage under a state Guarantee Access Plan (GAP). These GAPs are loosely modeled after existing high risk pools and would provide coverage for uninsured individuals with the highest expected medical costs (i.e., those whose claims costs are expected to be 200 percent or more of the statewide average).

If an individual is not eligible for coverage through the GAP, health plans would then provide coverage to that individual on a guarantee issue basis with premiums capped at 150 percent of the standard rate. Our proposal also would make coverage available through the GAP – *without* preexisting condition exclusions – for individuals who maintain continuous coverage or who apply for coverage during a one-time open enrollment period when a GAP is first established.[1]

To keep coverage as affordable as possible, our proposal calls on states to allow health insurance plans to offer features such as pharmacy programs that promote both value and safety; disease management, preventive, and care coordination programs that bring evidence-based care into everyday practice; and new benefit design and payment incentives that reward quality and value. We also encourage states to create a sliding-scale premium subsidy program with additional assistance for those with high health care costs and, additionally, to fund the GAP from a broad base of sources to ensure that coverage remains affordable for those who are currently insured.

[1] This proposal goes further than existing federal law under HIPAA, which requires the guaranteed issue of coverage for those seeking coverage in the individual market under certain conditions, unless those individuals were terminated under their previous coverage for fraud or nonpayment of premiums. 42 U.S.C. § 300gg-41.

Constructing an Individual Mandate for Coverage

AHIP's proposal also recognizes that neither rescissions nor preexisting condition clauses would be an issue if universal coverage existed. Accordingly, our proposal outlines five critical steps that states would need to follow if they seek to achieve universal participation by requiring that every citizen in the state have health care coverage. If a state takes these steps and achieves universal participation, health insurance plans could then *guarantee coverage to all applicants*. While AHIP is not advocating an individual mandate, we have explored this issue and have identified five critical steps that states should take as part of any strategy for achieving universal participation:

- develop an insurance coverage verification system;
- enforce the requirement to purchase and maintain coverage;
- establish an automatic enrollment process and be prepared to provide backstop funding if individuals do not fulfill their responsibility to purchase coverage;
- create a premium subsidy program for moderate- and low-income individuals and families, while also providing additional assistance for those with high health care costs; and
- fund coverage initiatives from a broad base of sources.

The establishment of a universal participation program, based on these steps, could avoid the unintended consequences that have hampered many well-intentioned efforts by states to assist those pursuing coverage in the individual health insurance market.

All of AHIP's initiatives have been developed with the goal of enhancing peace of mind for consumers who purchase coverage in the individual health insurance market and are concerned about having their policies rescinded or having a claim denied under a preexisting condition exclusion in their policies.

AHIP's Consumer-Centric Rescission Principles

Our specific policy proposals are based on a set of seven principles, endorsed by AHIP's Board of Directors, that are the cornerstones of what we believe are the responsibilities of health plans to ensure consumer-centric rescission practices:

1. Clarity in application: In reviewing an application, the health plan should identify any apparently inadequate, unclear, or otherwise questionable information on the application prior to issuing a policy, and should be responsible for obtaining clarification from the consumer prior to issuing a policy.

2. Written underwriting standards: The health plan should rely on written underwriting standards that govern the risk undertaken by the health plan at the time of the application, and should be willing to disclose the reason for an underwriting action to consumers upon request.

3. Information on which rescission is based: The health plan should limit rescission actions to those based only on information that should have been included in a complete and accurate response to questions asked in the application. If the health plan failed to conduct a thorough review of unclear or questionable information from the application process, and, based on that review, failed to seek additional information from the applicant, information subsequently obtained by the health plan may not be used as the basis for rescinding coverage.

4. Prompt investigation: The health plan should undertake a rescission investigation within a reasonable time after obtaining the information prompting the need for an investigation; should make reasonable efforts to obtain, in a timely manner, any additional information needed to complete the investigation; and should complete the investigation within a reasonable time after receipt of or efforts to obtain any necessary additional information. The health plan may not rescind a policy while an investigation is in progress.

5. Procedural steps if there are possible grounds for a rescission: If a health plan, following an investigation, determines that grounds for rescission exist, the plan should:

- notify the customer of the information that has been obtained;

- explain the specific reasons why coverage may be rescinded;

- provide a reasonable time period for the customer to respond with additional information;

- provide clear instructions on how to submit such information; and

- keep the customer apprised of delays because of difficulties in obtaining information.

The plan should promptly review such information, if submitted, and should advise the customer regarding the plan's decision to maintain the policy as issued, reissue the policy subject to revised terms, or proceed with rescission.

6. Evidence must be reliable and preexisting: The health plan's decision to rescind a policy should be based on reliable evidence and should be consistent with the criteria used to initially underwrite the policy. The information on which the health plan seeks to rescind coverage must be material to the risk undertaken by the health plan at the time the policy was underwritten. For example, information about a health condition or treatment arising subsequent to the issuance of the policy may not be used as the basis for, or considered relevant to, a proposed rescission.

7. Need for internal appeal process: Health plans should have a full, fair, and clearly stated internal appeal process, and should clearly inform customers of their right to access the process if they wish to dispute a rescission or a claim denial based on a preexisting medical condition. The process should, at a minimum, include an opportunity to appeal to reviewer(s) distinct from the initial decision maker, and should include review by a medical professional, as appropriate.

III. Background: The Individual Health Insurance Market and Rescissions

To put the issue of rescissions, which is the Committee's focus today, in context, it is helpful to summarize some important facts about who comprises the individual market and what consumers find when they seek to buy individual health coverage.

AHIP published the largest survey of this market in December 2007, and found that individually-purchased health insurance is more affordable and accessible than may be widely known and that it offers a broad array of benefits. AHIP's survey found that consumers in the individual market were offered a wide range of benefits, including mental or behavioral health, prescription drugs, preventive, and maternity benefits. In terms of accessibility, the survey showed that fully 89 percent of applicants who went through the application process were offered coverage in the individual market. Forty percent of these offers were at standard premium rates and 49 percent were offered at lower (preferred) rates.

In terms of affordability, annual premiums nationwide averaged $2,613 for single coverage and $5,799 for family plans in the 2006-2007 period. Since the states are the primary regulators of the individual market, premiums varied by state (as shown in the table below), reflecting a variety of factors, including particular state premium rating and underwriting rules, as well as differences in health care costs and demographics. Premiums were significantly higher in states with "guaranteed issue" and "community rating" requirements that place restrictions on premium variation and underwriting.

Individual Market, Average Annual Premiums by State Single Coverage, 2006-2007	
State	**Average Annual Premium**
MASSACHUSETTS	$8,537
NEW JERSEY	$5,326
NEW YORK	$4,734
RHODE ISLAND	$4,412
PENNSYLVANIA	$3,949
MAINE	$3,686
LOUISIANA	$3,377
NEW HAMPSHIRE	$3,368
NEW MEXICO	$3,362
CONNECTICUT	$3,326
NEVADA	$3,118
NORTH CAROLINA	$3,080

SOUTH CAROLINA	$2,981
FLORIDA	$2,949
SOUTH DAKOTA	$2,914
MONTANA	$2,866
TEXAS	$2,782
WYOMING	$2,688
NATIONAL	**$2,613**
ARIZONA	$2,591
CALIFORNIA	$2,565
WEST VIRGINIA	$2,540
COLORADO	$2,537
KENTUCKY	$2,537
MISSOURI	$2,518
NEBRASKA	$2,505
INDIANA	$2,504
ILLINOIS	$2,499
OHIO	$2,498
MISSISSIPPI	$2,489
OKLAHOMA	$2,435
MINNESOTA	$2,424
GEORGIA	$2,419
KANSAS	$2,363
VIRGINIA	$2,359
DELAWARE	$2,346
NORTH DAKOTA	$2,316
TENNESSEE	$2,221
MARYLAND	$2,208
ALABAMA	$2,208
IOWA	$2,202
ARKANSAS	$2,153
WASHINGTON	$2,015
IDAHO	$2,006
MICHIGAN	$1,878
UTAH	$1,574
OREGON	$1,297
WISCONSIN	$1,254
Source: America's Health Insurance Plans	

Note: Results from Alaska and the District of Columbia, where the responding companies reported fewer than 500 policies in force, are included in the national totals but are not reported separately.

In short, for those Americans who do not receive private health coverage through their employers, the individual market remains affordable and accessible, and we are working to make it even more so. Today, statistics show that over 18 million Americans have coverage in the individual market. To assure them affordable coverage, individual insurance is generally

underwritten, which means employing a process to assess risks and classify them according to their degrees of insurability so that the appropriate rates may be assigned. Without such underwriting, most people who purchase insurance in the individual market would pay considerably more for their health insurance premiums.

The basic principle is that insurance works when there is an average mix of people who are more healthy and people who are less healthy. When individuals wait until they are ill before purchasing health insurance, costs are increased for other policyholders who pay into the system on a regular basis.

In very rare cases, a health insurance contract will be "rescinded," that is, revoked by the insurer.[2] How often does this occur? Statistics show that it is rare, occurring in about two-tenths of one percent of cases. While state law varies, generally an insurer may rescind a policy, at least for an initial period of time after issuance, if the application contained misleading information or omitted information that would have caused the insurer to either not issue the policy or to issue it at a different price or with different terms and conditions.

State law, as noted, heavily regulates insurers' underwriting practices and any rescissions of coverage. The vast majority of states require application forms to be filed and some require specific approval before an insurer can use the application form. In addition, many states regulate the content of the application form. Moreover, states require health insurers to follow certain consumer protection standards when initiating the rescission of an individual policy, and many states have utilized the NAIC Model Law, which AHIP supports, in formulating their rescission-related requirements. The majority of states, for example, require a policy to include a provision prohibiting the use of misstatements, except fraudulent misstatements, to void a policy after two years of the date of issue. In addition, all states require health insurance plans to provide mechanisms for handling grievances and appeals.

[2] Rescission -- the retroactive termination of a policy -- should be distinguished from "post-claims underwriting," which is the practice of evaluating unclear or questionable information in an insurance application after the policy has been issued. It does not necessarily lead to rescission, but may lead to revised higher premiums, or limitations on coverage. AHIP's Board principles, as noted, discourage post-claims underwriting, and provide that the failure of the health plan to conduct a thorough review at the application stage precludes the health plan from using information subsequently obtained as a basis for rescinding coverage.

IV. Research on Unintended Consequences of Previous State Initiatives

Last year, AHIP commissioned research that yielded important lessons about the unintended consequences that can result when certain health insurance reforms are enacted in the absence of universal coverage. A report by Milliman Inc. examined eight states – Kentucky, Maine, Massachusetts, New Hampshire, New Jersey, New York, Vermont, and Washington – that enacted various forms of "community rating" and "guarantee issue" laws in the 1990s.

The Milliman report found that these initiatives, when enacted without universal coverage, drive up health care costs for consumers, limit access to coverage, and have unintended consequences for healthy persons. The report also found no significant decrease in the uninsured population in states that implemented these initiatives. As a result, several states that initially implemented community rating and guarantee issue laws have since repealed or modified their laws with the intent of stabilizing the insurance marketplace and providing consumers more choice and access to coverage.

These and other findings of the Milliman report are well worth considering in any congressional debate about rescissions or preexisting conditions. The clear lesson for policymakers is that any reforms that give healthy people incentives to delay purchasing coverage will lead to unintended consequences for the broader population. Specifically, it will cause premiums to increase for all policyholders, increasing the likelihood that lower risk individuals choose to leave the market, and thus cause further rate increases. This will ultimately diminish access to high quality, affordable health insurance. Instead of pursuing piecemeal reforms that have been tried before by states and create the unintended consequence of exacerbating existing problems, Congress should consider the challenge of ensuring that individuals with high health care costs receive coverage as part of broader policy changes that would bring meaningful relief to health care consumers.

V. Conclusion

Thank you again for this opportunity to testify. AHIP and our members stand ready to work with you to advance solutions for providing health insurance to the uninsured. We also look forward to participating in a serious debate on the broader challenge of extending coverage to all Americans to ensure that no one falls through the cracks.