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**TESTIMONY OF
ATTORNEY GENERAL RICHARD BLUMENTHAL AND
HEALTHCARE ADVOCATE KEVIN LEMBO
BEFORE THE INSURANCE AND REAL ESTATE COMMITTEE
FEBRUARY 24, 2009**

In Support of HB 6531, An Act Clarifying Postclaims Underwriting

We appreciate the opportunity to support House Bill 6531, *An Act Clarifying Postclaims Underwriting*.

This legislation clarifies the intent of legislation, jointly supported by our offices and the Insurance Department, to provide fairness and equity for individuals who are insured through individual health insurance. Specifically, House Bill 6531 requires the Insurance Commissioner’s approval on any rescission, cancellation or limitation of an individual health insurance policy after the insured files a claim. The Insurance Commissioner must review the proposed action by the insurer and grant approval only if the Commissioner determines that the insured was fairly apprised of the specific information sought in the application for insurance and failed to provide full disclosure. In addition, if the reason for the insurer’s proposed action is based on a preexisting medical condition, the Commissioner may approve such action only if the preexisting medical condition has a direct relationship to the insurance claim and the insurer has not violated statutory limits on how far back it may look to review such preexisting condition.

Over the years, our offices have received complaints from patients who have paid thousands of dollars in health insurance premiums only to have the insurer decline coverage for serious illnesses such as cancer. The insurer may cite a supposedly false statement on the application signed by the individual. In one example, the patient was tested prior to filing an insurance application for kidney disease and received a clean bill of health as a result of a negative and dispositive test result. Three months after enrollment the patient was hospitalized on an emergency basis and her insurance company retroactively terminated her policy, citing as its basis for doing so a statement she made to a question on the application which asked whether she had received consultation for kidney disease. The patient, who reasonably believed she had no kidney disease, answered “no.” The health insurer’s termination of her policy forced her to pay tens of thousands of dollars out of pocket for an unforeseen condition that she had every reason to believe would be covered. There was clearly no intent to deceive the insurer.

These retrospective reviews happen all too frequently -- well into the policy period at a time when patients have good reason to believe they are protected by the coverage they have purchased. Many have suffered severe harm.

In 2007, the General Assembly approved a law designed to prevent these abuses. Unfortunately, the law's effectiveness and efficacy in protecting insureds has been undermined by the Insurance Department's interpretations of the law. House Bill 6531 seeks to clarify the original intent of the law, restoring its true protections for insureds.

Upon the passage of the original act, P.A. 07-113, we believed that the law would reduce the number of rescissions in the short-term market, where medical underwriting does not play a factor. In fact, we and the Insurance Department agreed at the time that the short-term market had taken off and historically been a breeding ground for conduct such as rescissions and pre-existing condition limitations.

Under the Department's interpretation, as long as an insurer, in its own judgment under limited guidance, has completed "medical underwriting," then the insurer can skip the prior approval process and rescind a policy. This undermines the original legislation for several reasons: 1) short-term policies are not medically underwritten -- medical underwriting involves much more than the truncated process approved by the Insurance Department in the short-term market; 2) the Insurance Department has approved the use of a filled out form for short-term insurance as a substitute for medical underwriting; and 3) because the Insurance Department has, in effect, eliminated any meaning to medical underwriting no company has admitted that it hasn't completed medical underwriting. You heard Ms. Gelinas tell the story of her short-term policy application. That is just one example of the serious problem consumers face under the Insurance Department's interpretation of the law.

The Insurance Department sent out a very limited data call to short-term insurers this year, after Congress requested that it do so. (Abuses in the individual market are the subject of broad investigation.) The first question asks insurers for the number of times they rescinded policies for which they failed to complete underwriting, as defined by the Department. Seven companies responded. What were their answers?

Aetna Life Insurance Company	None
Connecticare Inc.	None
American Enterprise Group, Inc.	None
Anthem Health Plans, Inc.	None
Golden Rule Insurance Company	None
Celtic Insurance Company	None
Time Insurance Company	None

No surprise here. When an insurer is allowed to determine for itself, without review, whether or not it completed medical underwriting, we cannot be surprised at its response. It's very much the fox guarding the hen house.

Shortly after the Insurance Department issued its data call, the Office of the Healthcare Advocate believed that the survey sent to insurers failed to capture the real picture. So, OHA

sent a follow-up survey, in an attempt to determine whether the situation improved under P.A. 07-113 and the Department's interpretation of it. Despite the failure of several companies to respond to this statutorily authorized survey on the monitoring of the implementation of new laws, the information received thus far paints a different picture than the Department's on the law's effectiveness, and this is directly traceable to the Department's interpretation. We look forward to sharing the findings once the effort is complete.

The purpose of P.A. 07-113 was to shift the burden of proof from consumers to insurers. Rescission is a drastic remedy and should only be applied where the insurer can prove to a third party that its process was legitimate. It is clearly an abusive insurance practice to search years of medical records from multiple providers to find the slimmest possible and potentially unupportable evidence of a pre-existing condition based on a five-question broadly worded application, and rescind a policy with no opportunity for the enrollee to challenge the process. Yet that is what is occurring now.

Insurers that write short-term individual policies claim that they do not rescind enough policies to make this law necessary. They also commonly claim that they would go out of business if they had to go through a prior approval process for each rescission. One look at the Insurance Department's own numbers easily refutes those contentions. As an example, Golden Rule had 8,933 policies in effect between October 1, 2007 and October 1, 2008. It rescinded 28 policies during that same period or 0.3% of the policies. Although each rescission was potentially catastrophic for the patients and families, the burden of a prior approval would have been minimal for Golden Rule and does not support the argument that requiring prior approval before rescission would force insurers out of the market.

Consumers presently do not have the right to an external appeal for rescissions. Leaving the final decision on rescission to the insurer on a high-value claim virtually guarantees that the rescission will take place. An outside review of such a life and death action is necessary to prevent continued abuse in the market.

Revising the current law clarifies that:

- medical underwriting involves considerations beyond the filling out of an application;
- short-term policies of six months or less are not medically underwritten; therefore, their rescission requires Insurance Department approval
- the burden is on insurers to go through the prior approval process in EVERY case to prove knowing misstatements or omissions in applications prior to rescission, cancellation or limitations;
- no insurer is allowed to undertake an investigation for records from providers beyond those directly related to an alleged pre-existing condition;
- brokers will be held responsible for their conduct in assisting consumers with applications; and

- uniform and less confusing applications shall be used, and clearly define the meaning of terms such as “signs” or “symptoms”.

As more and more people are unemployed or taking lower paying jobs without access to employer health insurance, they will turn to individual health insurance. The legislature needs to provide this growing number of people with additional protection from unfair and arbitrary actions by certain health insurers.

We urge the committee’s favorable report on House Bill 6531.