Testimony of Kevin P. Lembo
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Before the Insurance and Real Estate Committee
In support of S.B. 12
An Act Clarifying Postclaims Underwriting
February 11. 2009

Good afternoon, Representative Fontana, Senator Crisco, Senator Caligiuri, Representative D'Amelio, and members of the Insurance and Real Estate Committee. For the record, I am Kevin Lembo, the State Healthcare Advocate. My office is an independent state agency with a threefold mission: assuring managed care consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health insurance plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems.

I am here today to testify in favor of a joint proposal of the Office of the Healthcare Advocate and the Office of the Attorney General, S.B. 12, An Act Concerning Postclaims Underwriting. Specifically, the bill 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 that the insurer has not violated statutory limits on how far back it may look to review such preexisting condition.

S.B. 12 is identical to the bill proposed last year that passed by a margin of 11236 in the House—148 voting—and unanimously in the Senate. (The committee might refer to HB 6531 of the 2009 Session to see the bill language or the attached proposed language for this year.) The bill was vetoed by Governor Rell.

A year later, this bill is no less needed. Even if federal healthcare reform passes, the provisions in the existing federal bills addressing rescissions do not provide the same level of consumer protections and safeguards to adequately protect consumers from the potentially catastrophic medical and financial effects of rescissions, cancellations or limitations of their insurance policies.

In practice rescission is a drastic remedy that results in severe and sometimes catastrophic consequences to an insured. Cancellations and limitations can lead to similar problems. A rescission is the termination of a policy back to its inception date (or retroactively) and results in the recoupment of all payments made by insurer to all providers. While a rescission results in the refund of the insured's premiums, practically, it is as if the policy never existed, leaving the consumer liable for all of his or her medical bills up to the amount(s) the providers charge. This could turn an expense for a procedure that was billed at $50,000, but reimbursed by the insurer at $25,000 with no liability to the consumer for any balance, into an unpaid balance to the consumer of the full charge of $50,000. And until federal legislation passes or Connecticut specific reform passes preventing insurers from

denying coverage on the basis of a preexisting conditions, a rescission, cancellation or limitation can leave a Connecticut consumer uninsurable or underinsured. Further, the subsequent "uninsurability": of consumers whose policies have been rescinded because of preexisting conditions results in cost shifting to the insured population.

It should not be easy for an insurer to rescind a policy—the insurer should bear the burden of showing misconduct on the part of the insured. Rescission should be rare as it is designed to be a remedy of last resort. All other remedies should be examined and exhausted; strict policing and strong safeguards need to be in place to guard against the irreparable devastation wrought by an improper rescission. S.B. 12 puts the currently missing safety check into the process. It sets up a last independent check to ensure the insurer's request to rescind is based on a thorough and accurate investigation of the facts, and it places a limit on the scope of such an investigation. It guards against abuses in the telephonic application process and broker misconduct. S.B. 12 is the only vehicle that guaranteed consumers these protections. Current law, P.A07113, does not provide these safety measures.

We would not be here again today if P.A. 07113 were working as intended when we took part in its negotiations three years ago; it was the Insurance Department's narrow interpretation of that Act that led us to introduce the proposed bill. The Insurance Department's interpretation has led to only a few requests for prior approval of rescissions. P.A.. 07113 was intended to require prior approval of rescissions, cancellations or limitations when underwriting is completed. The Insurance Department allows short-term policies to escape the prior approval process by allowing insurers to claim that their short-term policies are medically underwritten – even though insurers admit that they do not medically underwrite short-term policies.[1] The Department essentially communicated the following message to insurers: if you complete medical underwriting as determined by you and you alone, you can rescind, cancel or limit a policy unilaterally, with no third-party review. S.B. 12 eliminates this major loophole in PA 07113.

Unlike P.A. 07113, S.B. 12 would prohibit insurers from using their investigation of a possible preexisting condition as a mechanism for undertaking a fishing expedition to try to find any other possible error on an application or other preexisting condition as a basis to rescind the application. Further, under S.B. 12, there is no circumstance under which an insurer that writes short-term policies or other policies of under one year in duration can avoid the prior approval process. Unlike under P.A. 07113, this bill forces the insurer to seek prior approval before rescinding the policy.

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[1] Insurers do not review medical records in advance of approving an application for individual insurance policies of one year or less. We've been told repeatedly over the years that such medical underwriting is not done for these policies because of the delay underwriting can cause when issuing a policy and the cost for doing such underwriting, which makes the issuance of the short-term policies cost prohibitive. The short term policy market is the market in which most rescission abuses take place. We limited the bill to short term policies of one year or less in duration.

What S.B. 12 does

- Defines Rescission, Cancellation and Limitation in statute for the first time.
- Requires consumers to accurately depict their medical condition(s) accurately to the best of their knowledge
- States that any individual policy of six months or less duration will not be considered medically underwritten and must, in each case, be subject to prior approval before it can be rescinded, cancelled or limited;
- Clarifies that no other policy can be rescinded, cancelled or limited for any reason without approval from the Insurance Commissioner unless the insurer or health center can prove first, through a submission to the Insurance Commissioner, that it completed medical underwriting and second, that it carries its burden through the prior approval process.
- Leaves intact the consumer's state of mind standards of P.A. 07113; i.e., the insurer must prove that the consumer knowingly omitted or misrepresented material information or should have known that he or she omitted or misrepresented material information on the application or that the consumer knowingly misrepresented (or omitted)
- Narrows the scope of an insurer's investigations of preexisting conditions to the condition that was the subject of the trigger for the investigation — reins in the practice of engaging in fishing expeditions in order to find a reason to rescind a policy.
- Requires the recording of telephonic applications, followed by an opt out choice if it turned out that the application sent to a consumer after the telephonic application process was inaccurate.
- Limits the time period of investigation of a claim for a preexisting condition to the retroactive time period for consideration of a preexisting condition exclusion in C.G.S. § 38a476;
- Requires the Insurance Commissioner to review all applications and forms for compliance with preexisting condition limitations
- Makes the individual insurance market accountable

What S.B. 12 does not do:

- It not change the standard by which omissions or misrepresentations are reviewed
- As with P.A. 07113, it does not encourage consumer misconduct.
- It does not change the standard or burden of proof on insurers with respect to rescissions, cancellations or limitations.

Despite the fact that the pending federal proposals don't go as far as we'd like them to, the movement on the federal and state levels is to curb insurer misconduct. For instance,

toward the end of the June 16, 2009 Congressional hearing of the Committee on Energy and Commerce and its Subcommittee on Oversight and Investigations, Representative Joe Barton (R) TX, Ranking Member of the Committee on Energy and Commerce asked this question of the three insurer panel members—WellPoint, UnitedHealthcare and Assurant Health were represented:

"Doesn't it bother you that people are going to die because you insist on reviewing a policy that somebody took out in good faith and forgot to tell you that they were being treated for acne? Doesn't it bother you?"

The only person to respond was Assurant's President and CEO, who stated:

"Yes sir, it does, and we regret the necessity that it has to occur even a single time, and have made suggestions that would reform the system such that would no longer be needed." (Emphasis added)

The question and answer encapsulate the need for this bill. Certainly the insurers are not going to change their behavior on their own, and to date the Connecticut Insurance Department has not taken any meaningful step to prompt the industry to change. This issue is vitally important for consumers in Connecticut, especially in an economic climate where people turn to the individual insurance market after losing employer sponsored coverage.

Connecticut must continue its role as a national leader on the issue of postclaims underwriting abuses, and be ready and willing to protect its residents.

Thank you for considering this proposed bill to prohibit postclaims underwriting abuses.