

Post Claims Underwriting and Rescission Practices

Peter Harbage, MPP
Hilary Haycock
Meredith King Ledford

Harbage Consulting



Robert Wood Johnson Foundation

Contents

Executive Summary.....	3
Introduction	4
Background.....	5
Legal Standard.....	6
Regulatory Enforcement and Federal Oversight.....	9
Looking Ahead to Change the System	12
Conclusions: Lessons for Insurance Regulation	15
Methodology	17
About the Paper.....	18
About the Authors	18
References.....	19
Appendix One: California Case Study.....	21
California Regulations	21
California Regulatory Enforcement	23
Changing the System – Recent Work on Rescission and Enforcement.....	25
Appendix Two: Connecticut Case Study	28
Connecticut Regulations	28
Connecticut Regulatory Enforcement.....	30
Changing the System – Recent Legislative Work on Rescission and Enforcement	32
Appendix Three: Florida Case Study.....	33
Florida Regulations.....	33
Florida Regulatory Enforcement.....	35
Role of the Federal Regulators in Florida	36
Looking Ahead – State Action of Rescission and Enforcement.....	36

Contents (continued)

Appendix Four: Texas Case Study	37
Texas Regulations	37
Texas Regulatory Enforcement	38
Role of the Federal Regulators in Texas.....	39
Looking Ahead to Change the System – Recent Legislative Work on Rescission and Enforcement	40
References.....	43

Post Claims Underwriting and Rescission Practices

Executive Summary

Regulation of the individual (non-group) health insurance market is conducted through a mix of federal and state efforts. While federal law primarily delegates insurance regulation to the states, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) offers important consumer protections that states are to enforce. Among other things, HIPAA requires health insurers to renew or continue health insurance coverage at the policyholder's discretion, except in very limited circumstances, such as fraud or nonpayment of premiums. Based on a set of four case studies, this paper seeks to help policymakers understand what works — and in particular, what does not work — under the current system and how these failings can be overcome.

The practices of insurers who sell policies in the individual market have come under increasing scrutiny in recent years, particularly post-claims underwriting and rescission. Insurers routinely investigate the health status of policyholders who submit large claims to determine whether any health information, even relatively minor or unrelated health problems, may have been overlooked at the time of application. If it is deemed so, insurers may rescind that coverage.

While research suggests that only a small proportion of individual health insurance policies are rescinded, those who lose coverage in this system are typically those who need it most. In Connecticut, for example, some patients died after their health coverage was abruptly ended, interrupting needed medical treatment. Others have gone into tens of thousands of dollars of debt for treatments received while they thought they were covered.¹ Individuals who have had their coverage rescinded are subsequently unable to find an insurer willing to sell them a new policy.² In many cases, these coverage rescissions were based on either inaccurate evidence of pre-existing conditions or on the existence of minor and unrelated pre-existing conditions. Robin Beaton of Texas had her insurance terminated based on the insurer's misunderstanding of a physician's note regarding acne. Her insurance was eventually restored, but this happened only after the involvement of her Member of Congress.

Given these and other cases where individual coverage policies were rescinded for seemingly arbitrary or legally insufficient reasons, state and federal policymakers have taken a strong interest in the issue. In a few states, changes in consumer protections are being considered and sometimes implemented. At the federal level, health care reform legislation would require insurers to issue policies to all those who apply, commonly referred to as called guarantee issue.

To gain a better understanding of these issues, we examined four states to identify how the individual insurance market is regulated today. The lessons from these states will help policymakers improve the existing system and inform them as they move forward with health reform. The paper offers a review of state laws, consumer engagement, and regulatory activity related to health insurance rescission through case studies from California, Connecticut, Florida and Texas. Where appropriate, our state specific research is supplemented by data collected by the US Congress and National Association of Insurance Commissioners.

In the four states we studied, state laws, regulations and enforcement all showed gaps in consumer protections. Indeed, state laws regarding guaranteed renewability of health insurance can be inconsistent and difficult to understand. State enforcement of consumer health insurance protections can also be inconsistent. While there are notable leaders in consumer protection, none of the states studied collect

enough information to know exactly what is happening in the individual insurance market with regard to post-claims underwriting and rescission.

The primary finding is that enacting laws alone is not sufficient to protect consumers. Private insurers will always have an incentive to shift high-risk enrollees out of their plans. As such, proactive oversight and regulation are needed to ensure that market rules are followed. The case studies offer several lessons and recommendations for federal policymakers seeking to transform the regulation of health insurance markets, regardless of the outcome of national health reform.

- **To the extent states continue to regulate insurance under health reform, state laws must clearly and consistently reflect the federal standards.** Federal policymakers and regulators must ensure that new insurance regulations developed by national reform are clearly and consistently incorporated into state law and regulatory enforcement structures.
- **Direct outreach and support on consumer rights must be expanded.** Consumers who fall ill are most vulnerable to health insurance problems, yet it can be hard for them to understand their rights and pursue them, particularly because they are sick. State and federal regulators must ensure consumers have information about protections guaranteed them by law and support them in navigating the insurance regulatory system.
- **Regulators must collect more detailed data about the health insurance markets they regulate and use specific criteria on when to carry out a market conduct review.** Many state regulators lack basic information about who is selling, buying and losing health insurance coverage in private markets. State regulators tend to rely on consumer complaints to trigger an investigation into questionable industry practices. Rather than rely on consumer complaint systems, regulators should more proactively monitor what is happening. In addition, the federal government must have accurate data on both the performance of insurers and regulators.
- **The federal government must take on a larger role to protect consumers.** States have long had the primary jurisdiction over health insurance. To create a new national standard for consumer protections in the private insurance market, federal regulators will need to work more closely with state regulators and monitor enforcement and compliance independently to ensure that every American has equal access to the health coverage they need and deserve. This must include federal technical assistance for states to achieve compliance with federal rules.

With reference to the health reform debate specifically, the experience with HIPAA is clear: For federal rules to be followed, the federal government must take an active role in implementation and ongoing operations. Absent an active federal role, health reform could result in the continuation of hit-and-miss protections that exist under HIPAA today.

Introduction

As Congress debates health reform, there is increasing interest in understanding the impact of private health insurance market practices on everyday Americans. Two such practices, post-claims underwriting and rescissions, can result in loss of coverage for individuals who submit large claims. For many, these are examples of the excesses and problems in the private health insurance markets that national health reform seeks to address.

Both federal and state laws govern the individual (non-group) health insurance market. The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) created a standard called “guaranteed renewability,” which is intended to protect policyholders in the individual market from losing their existing

coverage except in very limited circumstances, such as fraud or nonpayment of premiums. Under HIPAA, the federal government relies on states to adopt and enforce laws at least as protective as federal minimum standards.

However, there is reason to believe that HIPAA protections are not being followed widely. During the course of Congressional hearings, the chief executives of three insurance companies testified that they are unwilling to limit rescission activities to only cases where they could prove “intentional fraudulent misrepresentation,” as provided for by HIPAA.³ In explaining why he would not follow the HIPAA standard, the chief executive of Golden Rule Insurance Company stated, “We follow the state laws and regulations and ... [the HIPPA standard] is not consistent with each states’ laws.”⁴

This project sought to gain a better understanding of state laws governing guaranteed renewability and rescission, and what states are doing to enforce them through four in-depth case studies from California, Connecticut, Florida and Texas. The structure of this report is as follows:

- **Background.** Brief background on the issue of post-claims underwriting and rescissions.
- **Legal Standards.** Analysis of legal standards and how they differ between the federal level and each state studied.
- **Regulatory Enforcement and Federal Oversight.** Findings from the case studies on state insurance regulatory enforcement, including consumer education and outreach, complaint tracking and response, market conduct review, and federal oversight of state regulations and enforcement.
- **Looking Ahead to Change the System.** Overview of state legislative and regulatory action to improve state laws and enforcement related to rescissions and post-claims underwriting.
- **Lessons for Health Reform.** Lessons the case studies offer for federal reform on health insurance regulation.

Full case studies of California, Connecticut, Florida and Texas are available in the appendix.

Background

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, under what terms and at what price. Post-claims underwriting is a process where an insurer investigates the individual policyholder’s medical history after the policy has been issued, particularly after claims have been submitted.⁵ The purpose of look-back is to ascertain whether the underwriting process missed information that would have caused the insurance company to change its initial offer of coverage. If the investigation reveals new information that the insurer deems would have caused the initial application to be rejected, the insurer may cancel or discontinue the policy for future claims. Alternatively, the insurer may revoke the policy, refund already paid premiums and leave all claims submitted for the consumer to pay. This second type of action is referred to as rescission.

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 can rescind a policy if it determines the applicant committed fraud, such as 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 cases where there is clear and convincing evidence of fraud on the part of the applicant generally has not been controversial.

However, insurers have a strong financial interest to rescind coverage for individuals with costly medical conditions. The information discovered during the post-claims investigation may or may not be related to the claim that triggered the post-claims investigation. At a recent Congressional hearing, for example, 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.⁶ In so doing, the insurer was able to avoid paying potentially tens of thousands of dollars in medical claims for treatment of lymphoma.

The insurance industry argues that post-claims underwriting and rescission are necessary to defend against fraud and keep insurance affordable for all. Others argue that the insurer has a significant financial interest in rescinding the coverage of high cost cases, and this can make coverage less secure for all policyholders. Indeed, news reports found one insurer paid bonuses to staff based on number of rescissions and avoided losses.⁷ Critics suggest that the industry uses vague and confusing questions in insurance applications that are difficult for applicants to answer accurately and completely, thereby creating the basis for a future rescission. Insurers could also conduct less thorough (and less expensive) underwriting of applicants when coverage is first issued, knowing they can rely on post-claims underwriting to avoid incurring losses later. In any event, the post-claims underwriting process leaves the policyholder with significant risk.

Legal Standard

In this section, we examine the federal legal standard on guaranteed renewability. We found inconsistencies among state laws.

Federal Standard

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) created the “guaranteed renewability” standard to permit insurers to discontinue a policy only in limited circumstances. In relevant part, Section 2742 of the Public Health Service Act states:

“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.”⁸

The law requires not only that coverage be reissued when it comes up for renewal but also that insurers cannot discontinue an existing policy, except under the following five exceptions:

- The policyholder does not pay premiums;
- The policyholder moves out of the geographic area served by the policy;
- The policyholder leaves an association through which she had purchased coverage;
- The policyholder commits fraud (the exception most closely tied to rescissions); and
- The insurer discontinues the product in question for all policyholders.⁹

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.

State Standards

Our research suggests that there is a general lack of clarity and consistency between federal and state law in the four states studied. Indeed, in all four states, language in the insurance code can be found that contradicts the HIPAA fraud standard regarding sufficient cause for rescission, as shown in Chart 1.

For example, one section of Connecticut state law refers directly to the HIPAA guaranteed-renewability protection, but another would allow coverage to be canceled for individuals whose applications for insurance failed to include other information that “materially affected either the acceptance of the risk or the hazard assumed by the insurer.”¹⁰ This means that an individual can lose coverage for failing to disclose information that they “knew *or should have known*” (emphasis added) would impact the insurer’s decision to sell the individual coverage in the first place.¹¹ This difference is critical because under the Connecticut standard people unaware that they have a serious medical condition could still have their coverage rescinded, whereas the federal standard requires an intentional effort to mislead the insurer. A regulator from Florida interviewed for this project was more direct, stating that insurers have a two-year period to conduct medical underwriting, during which time consumers pay premiums but do not technically have health coverage.¹²

Three of the states studied allowed for such two-year time windows, known as “contestability periods,” which conflict with federal HIPAA standards. These state laws bar insurers from revoking coverage for any reason other than fraudulent misstatements or omissions in the application process after the policy has been in force for a period of time, usually two years.

Because fraud is the standard set by federal HIPAA law for all policies upon issuance, the concern is that these state laws allow a two-year loophole where HIPAA does not apply. The first two years of coverage are when it is believed that many individuals are more likely to face a rescission.¹³

Chart 1: *State Statutes Regarding Guaranteed Renewability and Contestability Periods*

State	Statute Consistent with HIPAA	State Rules on “Material Affect”	State Contestability Periods
California	“An enrollment or a subscription may not be canceled or not renewed except for . . . Fraud or deception in the use of the services or facilities of the plan or knowingly permitting such fraud or deception by another.” ¹⁴	“The falsity of any statement in the application . . . shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive <u>or</u> unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.” ¹⁵	“After two years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for the policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of the two-year period.” ¹⁶

Chart 1: (continued) *State Statutes Regarding Guaranteed Renewability and Contestability Periods*

State	Statute Consistent with HIPAA	State Rules on “Material Affect”	State Contestability Periods
Connecticut	“Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation and health care center shall comply with sections ... as set forth in the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) (HIPAA).” ¹⁷	“The falsity of any statement in the application ... may not bar the right to recovery there under unless such false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer.” ¹⁸	<i>None</i>
Florida	“Except as otherwise provided in this section, an insurer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual [unless] The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.” ¹⁹	<i>None</i>	“After two years from the issue date, only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred or disability starting after the two-year period.” ²⁰
Texas	“[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.” ²¹	<i>None</i>	“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.” ²²

In addition, the laws governing insurers can be especially complex and allow loopholes to exist. For example, in 2007, Connecticut became the only state that requires insurance companies to notify regulatory agencies and request permission in the event of some rescissions. The Connecticut Insurance Department (CID) requires insurers to seek approval for rescissions where medical underwriting was not conducted at the time of application, but insurers are allowed to decide when medical underwriting has been completed. If insurers assert that medical underwriting has occurred, they are allowed to rescind coverage without seeking approval – and are not required to prove to regulators that medical underwriting or consumer fraud in the application process occurred. This has led the Connecticut Office of the Healthcare Advocate to question whether insurers may be rescinding coverage where full medical underwriting was not conducted, creating a loophole. There is dispute over whether the law has decreased or increased the number of rescissions.²³

This analysis has important implications for national reform. More than 10 years after HIPAA created federal standards, conflicting provisions continue to exist under many state laws. If the federal government moves to limit rescission and make other insurance market changes, these case studies suggest the importance of going beyond simply changing the law. It is clear that simply passing a new federal law and hoping that states will enforce it is not sufficient for achieving the federal standards. At a minimum, the federal government must coordinate more closely with states to ensure that federal standards have been adopted correctly and are being enforced vigorously.

Regulatory Enforcement and Federal Oversight

State regulatory agencies have the primary authority to enforce health insurance regulations. To do so, states have three primary levers, all of which were part of the study:

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

Consumer Education and Outreach

All states in the study conduct some consumer education and outreach, but in even the most aggressive states, the burden typically falls to consumers to seek help. In all the states studied health insurance regulators operate websites with information on how to file complaints. They also require insurers to notify consumers of their right to contact state regulators at the time of a rescission.

Beyond posting information online, three of the four states studied engaged in other types of public education and outreach. For example, states can conduct public service campaigns and make presentations to community organizations.

Connecticut, California and Florida all have offices dedicated to providing advocacy on behalf of patients or consumers. Generally, those advocates are housed within the general insurance regulatory agency, and perform consumer outreach on behalf of the agency. Florida has the Office of Insurance Consumer Advocate which conducts outreach and assists policyholders with complaints and is housed within a state department charged with insurance oversight for consumers. Within California's Department of Managed Health Care (DMHC), which primarily conducts oversight of Health Management Organizations (HMOs), there is the Office of Patient Advocate. At the same time, California's Department of Insurance (CDI), which primarily oversees Preferred Provider Organizations (PPOs), does not have a specific advocacy position. In contrast, the Connecticut Office of the Healthcare Advocate (OHA) is an agency independent of the Insurance Department created in 1999 both to fill a perceived gap in consumer

advocacy in state government and to help patients in the growing managed care market.²⁴ The position of Healthcare Advocate is appointed by a commission independent of the Governor and Legislature.

Even in states that are proactive, some consumer advocates have suggested that this proactive consumer education and outreach may not be sufficient. One Connecticut stakeholder said, “It’s not just that consumers don’t know their rights, but that [regulations] are unknowable” even for highly educated consumers or for health care advocates experienced in the field.²⁵ One key challenge is that most consumers do not need to know their rights until they get sick and a conflict with their insurer arises. At that point, however, consumers are most vulnerable and face the double challenge of seeking treatment for their medical condition and advocating for their insurer to cover needed services.

Complaint Tracking and Response

None of the states in this study required insurers to report all coverage rescissions, and thus none had clear and full tracking of rescissions and coverage cancellations in their insurance markets. Instead, consumer complaints are the primary method most states use to track trends in the individual insurance market, although they may provide incomplete information. A Congressional inquiry into the number of rescissions in state markets found that just four states knew the number — either through existing records or through surveying insurance companies to determine the number.²⁶

Connecticut, which requires insurers to request permission before rescinding coverage for a narrow category of consumers, might be expected to have better data on rescissions, but there is some dispute over whether CID data tracking is adequately capturing the number of rescissions. The state otherwise relies on consumer complaint databases operated by both OHA and CID to track rescissions. As discussed in the appendix, OHA believes that a number of rescissions are not being captured by that system. And, there is some dispute over whether the law has decreased or increased the number of rescissions.

Texas showed how consumer complaint databases also may not fully capture the extent of rescissions in the state market. Texas typically relies on consumer complaint data to track insurance market trends, but was one of just four states which surveyed individual insurance carriers to find the number of rescissions in response to the Congressional inquiry. The survey revealed that 6,377 policyholders had their coverage rescinded between 2003 and 2007. However, the Texas Department of Insurance (TDI) reported receiving complaints from just seven individuals during the same period and only one of those complaints was determined to be justified. This major discrepancy indicates that consumer complaint databases are not a good indicator of the size or scope of the rescission issue in a given state.

Most states are able to identify trends in consumer complaint databases by type of complaint, such as coverage rescission, as well as by carrier. While these databases do not provide a complete picture of rescissions, they have helped some states identify trends for investigation. For example, consumer complaint databases helped Connecticut and California regulators in insurer investigations. The same type of data helped Florida regulators identify the out-of-state association market as a place where consumers may not be receiving all protections as outlined in state and federal laws. However, the consumer complaint trends were not the only reasons that these states launched investigations. Florida and California’s investigations were both triggered by media coverage of trends that were then corroborated with consumer complaint data. In Connecticut, the proactive consumer-oriented OHA office identified trends in just two or three rescission complaints per month, which had escaped the notice of CID. Connecticut’s OHA officials show the importance of proactive state oversight.

Consumer advocates have raised concerns about the complaint system. A California consumer advocate stated his organization believed “people shouldn’t have to get a lawyer to get health care,” but that is too often the case in the current system.²⁷ The implication of complaint-based enforcement is that the burden falls on the individual to understand the law and pursue a remedy. Given the highly technical nature of insurance regulation, there is a need for states to act as an advocate.

Market Conduct Reviews

In market conduct reviews, regulators examine insurers’ practices — including marketing, sales and claims payments — to determine if they are following state laws. States indicated they conduct market reviews following National Association of Insurance Commissioners’ guidelines. These reviews include insurer compliance with state laws regarding rescissions but not necessarily federal laws, such as HIPAA.

Regulators have the authority to conduct targeted market reviews as needed. Some states, notably California and Connecticut, have used market conduct reviews and investigations to delve deeper into insurer post-claims underwriting and rescission practices. The California investigations resulted in a series of settlements with the state’s largest insurers, where the insurers agreed to voluntarily change their rescission practices, reinstate coverage for rescinded policyholders, and pay large fines and penalties. The Connecticut investigation also resulted in fines and penalties for the insurer in question.

Texas regulators also have the ability to conduct such targeted exams, but have not exercised that authority. Texas’ regularly conducted market examinations, which include general investigations into insurer rescission practices, have not found evidence of unlawful behavior despite consumer complaint data to the contrary. This may be an indication that general market conduct exams may not be sufficiently targeted to identify concerns with rescissions.

Federal Role and Oversight

One of the most comprehensive statements on the role of the federal government with regard to rescission was presented at a 2008 Congressional hearing by Abby Block of the Center for Medicare and Medicaid Services (CMS). She testified that states have the “primary responsibility” for enforcing HIPAA.²⁸ Block also testified that “CMS can act only if it determines that a state fails to substantially enforce the requirement.”²⁹

Just as this study found that states laws are out of compliance with HIPAA, testimony at the hearing indicated that Utah is also not in compliance. Even though Block asserted that there is seemingly no real problem with state compliance, she created at least some uncertainty by saying that CMS believes that “vast majority of States” are appropriately enforcing.³⁰ While this seems to be an indication that CMS may believe that some states are not substantially enforcing HIPAA, there was no indication of CMS action on the issue. Block indicated that all states were reviewed when HIPAA was passed, but she gave no evidence of ongoing, active monitoring that occurs today. None of the states in our four-state case study indicated that they have received any support in their efforts from the federal government.

The ambiguity in understanding CMS’ effectiveness stems from several concerns.

- **Resources.** Block testified that there are only four “dedicated” staff for the entire American private insurance market. She also testified that CMS would investigate in the event it received a consumer complaint, but upon further questioning, acknowledged that the agency does not maintain a hotline or other mechanism for receiving consumer complaints. Nor does the agency actively engage in efforts to educate consumers about their federally guaranteed health insurance protections.

- **Role of Regulators.** Block described CMS authority as limited. She was clear that CMS has no authority to oversee the insurance marketplace, unless a state is found to be deficient in implementing HIPAA — a finding that has never been made. When asked about national news stories on the rescission of insurance, Block indicated that CMS has no obligation to act on media reports, even though one committee member at the hearing stated that CMS should act on such reports.
Also at the hearing, the CMS position was continuously presented as one where the federal government would take over jurisdiction of insurance regulation “as a last resort” if a state was found not to be in “substantially compliance” with federal rules.³¹ Congressman Murphy (D-PA) asserted that a state law contradicting HIPAA, as in Utah, was obvious evidence of non-compliance.
- **Mission.** Although not discussed at the hearing, it is worth mentioning that CMS is dedicated to operating federal health insurance programs (Medicare and Medicaid). The mismatch between the CMS primary mission and HIPAA enforcement of rules for private insurance could be a limiting factor on the federal government’s effectiveness.

A Note on Other States

The four states selected for this study were chosen because state legislators and regulators were actively looking at rescission practices in their insurance markets. This may suggest that these four states represent the high-end of state activity on this issue.

Looking Ahead to Change the System

Based on the case studies, all the states have specific issues they are addressing. For each state, Chart 2 summarizes the specific consumer protection successes and challenges. From that chart, the gaps in the regulatory process become more clear, particularly around data collection and the use of reactive (versus proactive) enforcement processes. We then discuss the changes that states are making to fill these gaps, with California and Connecticut providing significant leadership.

Chart 2: *State-by-State Lessons*

State	State Practices that Enhance Effectiveness of Consumer Protections	State Barriers to Effectiveness
California Demonstrates the importance of proactive regulators, and the challenges states have in collecting market data.	<ul style="list-style-type: none"> • Complaints about rescission triggered a thorough investigation of all major carriers and resulted in identification of market failings and legal settlements. 	<ul style="list-style-type: none"> • Despite aggressive work, California still lacks data to fully track rescissions. • With two different departments regulating health insurers, differences in laws and procedures can create confusion.

Chart 2: (continued) *State-by-State Lessons*

State	State Practices that Enhance Effectiveness of Consumer Protections	State Barriers to Effectiveness
Connecticut Demonstrates the ability of new structures to advocate for consumers and the challenges that can come with new state programs.	<ul style="list-style-type: none"> • New ombudsman's office allows focus on individuals and specific problems. • The requirement for insurers to report rescissions and seek prior approval in certain cases is an important step. 	<ul style="list-style-type: none"> • While the ombudsman adds important protections, authority is limited and not clearly linked to the enforcement process. • Legal loopholes remain a barrier to effective oversight.
Florida Demonstrates the ability of states to identify specific problems, along with the challenges that come from a complaint-driven data collection system.	<ul style="list-style-type: none"> • Work shows how state regulators were able to identify a specific problem with selling insurance across state lines. 	<ul style="list-style-type: none"> • Demonstrates the limits of states to regulate insurance and the challenges that arise from differences in state and federal laws.
Texas Demonstrates the ability of states to collect data and the need for regulators to be proactive.	<ul style="list-style-type: none"> • Effort shows that proactive data collection is possible, and that data collection (which found 6,400 documented cases of rescission) is more effective than a complaint-driven process (with seven rescission-related complaints over the same period). 	<ul style="list-style-type: none"> • Despite the complaint-driven system for identifying rescissions, state regulators have not acted on this information.

Ongoing Work

With these successes and challenges in mind, all the states are working on specific areas of change that can offer lessons to other states.

- **Regulatory Approval and Tracking of Rescissions.**
 - In response to consumer complaints, the Connecticut legislature changed state law in 2007 to require insurers to request approval from the Insurance Department before rescinding policies that were not fully medically underwritten. However, some people believe the law's implementation has not gone far enough to protect consumers, particularly those with short-term policies. In addition, regulators have left to insurance companies' discretion to decide which rescission cases should be reported for prior approval. In 2009, the Legislature passed a piece of legislation to correct some of the 2007 legislation's loopholes regarding short term policies, but it was vetoed by the Connecticut governor.

- OHA is considering pursuing a similar measure next session. The 2009 law would have required CID approval for any rescission of policies with durations up to one year.
- California lawmakers considered a bill in the 2009-2010 legislative session that would have required state regulators to create independent processes to review insurer decisions to cancel or rescind coverage. The legislation also would have required insurers to report the number of individual insurance policies issued, canceled or rescinded. The bill passed out of the Legislature and was vetoed by the Governor.
 - **Clearer Applications and Underwriting.** Regulators believe that rescissions and post-claims underwriting could be reduced if insurers used more understandable applications and conducted more complete medical underwriting at the time of application. Several states are trying to take steps to improve the individual insurance application process.
 - California regulators investigated the five largest individual market insurers and found them in violation of state anti-post-claims underwriting laws. These investigations resulted in settlements requiring the largest insurers to create applications that were clearer to the average consumer and to conduct medical underwriting in-full at the time of application. CDI is in the process of finalizing regulations which would extend those requirements to all insurers in the traditional insurance market.
 - **Policyholder Participation in Rescission Investigations.** Regulators have found that policyholders often may not know they are being investigated until their coverage has been canceled or rescinded. At that point, consumers may have limited recourse beyond filing a complaint with state regulators or suing the company. States have sought to provide policyholders with more input into the rescission process to try to resolve the issue prior to individuals losing coverage.
 - California's settlements with the largest insurers required impartial and transparent grievance procedures. The CDI is in the process of creating regulations to create a "fair due process" that would allow consumers to provide documentation and input to the insurer's rescission investigation.
 - Texas requires insurers to provide policyholders with 60-days notice before rescinding coverage and to notify policyholders of their right to contact state regulators with concerns that the rescission may be inappropriate.
 - **Requiring Insurers to Pay Claims.** When policies are rescinded, they are canceled back to the date of issue. Insurers refund the premiums the policyholder had made, and the individual then becomes responsible for paying for all their medical bills – often including any services delivered when coverage was thought to be active.
 - California, under a new law, AB 2569, prohibits insurers from recouping claims already paid to providers on a policy that has been rescinded. This is designed to financially protect both the policyholder and the physician who acted in good faith under the assumption that the policy was valid.
 - Texas sought a similar protection for consumers in the most recent legislative session, but the bill failed to pass.
 - **Prohibiting Performance Bonuses for Rescissions.** Both California and Texas have passed laws forbidding insurers to base insurance company employee compensation on the number of policies rescinded or claims denied.
 - **Efforts to Increase Insurer Penalties and Limiting Rescissions.** In California, the state legislature has passed several bills on the regulation of the individual market. One bill passed increased the penalties the CDI can enforce from \$118 to \$5,000 per violation, and \$10,000 if the insurer "knew or had reason to know the act was unlawful." The Governor vetoed this bill.³² A

recent California bill that the Governor signed, states that no individual market health insurance product can be rescinded for any reason, including fraud, after 24 months.³³

- **Maintaining Coverage for Family Members.** California law requires that all other individuals or family members covered under the policy of an individual whose policy is rescinded must be allowed to keep their coverage. Texas sought a similar provision in the recent legislative session, but this bill did not pass out of the legislature.

Conclusions: Lessons for Insurance Regulation

The experience with HIPAA offers profound and important lessons for the role of the federal government in working with states to regulate markets. Clearly, it is not enough for the federal government to simply pass legal protections and expect those to be followed. To date, federal regulators have had a limited enforcement role in HIPAA. Federal regulators report that states are adequately enforcing HIPAA protections, despite clear examples to the contrary.³⁴

By remaining in a reactive mode to enforce HIPAA, the federal government depends on consumers to complain about illegal behavior when there has been only a limited effort to educate consumers about state and federal protections. If states continue their lead role in insurance regulation enforcement, the case studies show that effective oversight needs proactive steps, including:

- **Technical Assistance to States and Insurers.** The federal government has an obligation to offer technical assistance to state regulators so that there is a shared understanding of the legal requirements.
- **Independent Review.** The federal government must have authority and the operational ability to review state and health plan conduct as needed.
- **Additional Data.** For protections in place today and put in place in the future, there must be sufficient data collection to determine if rules are being followed. Without transparency, there can be no accountability.
- **Appropriate Penalty.** Under HIPAA, states failing to enforce federal rules risk losing jurisdiction of health insurance regulation. There must be some more appropriate means of requiring state compliance in insurance regulation. Other federal health programs may provide useful lessons here, such as Medicaid, the state-federal partnership to provide health insurance to low-income persons. If states that fail to follow Medicaid rules, then that state risks losing federal funding.
- **Proactive Oversight and Enforcement.** More proactive monitoring and enforcement is possible. For example, prior approval requirements can provide for closer review of rescission decisions. Requirements of advance notice, appeal rights, and rules that prohibit paid claims from being recouped can protect consumers and reduce the financial incentive to rescind policies inappropriately. Use of more targeted market conduct examinations in response to even a small number of complaints can bring to light harmful patterns and practices before they affect large numbers of consumers.

Beyond the role of the federal government, the case studies offer important insight to what can be changed at the state level to strength consumer protections. Chart 3 outlines these specific findings, as well as the lessons those findings provide for national health reform efforts.

Chart 3: *State Lessons for Health Reform*

	Finding from the States	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 explained easily to consumers, enforced by regulators and followed by insurance companies.
Consumer Education and Outreach	Consumer outreach and education is largely limited to passive websites and notices that 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 canceled. Insurance regulators should also provide this information to consumers.
	Independent patient advocacy agencies can effectively serve as the voice of the consumer in seeking improvements to state laws and regulations.	Consumer rights are best protected when there is a state advocate supporting them. While a regulator could be effective, the case study suggests that an advocate separate from the regulator could be most effective.
Complaint Tracking and Response	<p>Consumer complaints may not provide complete information for regulators to ensure laws are enforced.</p> <p>States can have limited understanding of what is happening in the insurance market.</p>	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 market activities. This is data that insurers have readily available.

Chart 3: (continued) *State Lessons for Health Reform*

	Finding from the States	Lesson for National Reform
Market Conduct Reviews	Not all states carry out market conduct reviews to ensure enforcement of federal standards.	Once effective complaint tracking is in place, standards can be set to trigger market conduct reviews. All regularly scheduled market conduct reviews should investigate insurer compliance with all state and federal regulations. Federal government must take a more proactive role in enforcing rules.
	Consumer complaint databases may not provide regulators with a complete understanding of how insurance markets are operating and may not be the best means of triggering market conduct reviews.	Periodic audits should be used to ‘spot check’ compliance with rules.

Regardless of the outcome of national health reform, these recommendations are critical. Under any system of private insurance, health plans will always have an incentive to shift the most expensive cases from their product to another insurer. As a result, effective oversight is needed to ensure that plans are not attempting to drive expensive patients away from their products. Further, strong federal oversight is important if consumer protections are to be applied consistently across the states. Federal regulators 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.

Since the health reform bills under consideration delay implementation of full-market changes for years, these lessons could be implemented immediately to create consumer protections during the transition period to a new system. In the absence of national health reform, the federal government should consider the lessons here as a means to increase consumer protections and implement the HIPAA protections. Under health reform, the lesson is that there must be aggressive federal oversight of both states and insurers. The federal government must be a present and active partner in health insurance regulation.

Methodology

California, Connecticut, Florida and Texas were selected for these case studies based on a series of preliminary interviews with leading policymakers and advocates familiar with post-claims underwriting at the state and federal levels. These preliminary interviews revealed California and Connecticut as two states with an active policy debate on strengthening consumer protections in post-claims underwriting. While Texas appears to be typical in terms of existing state laws and regulatory enforcement around this issue,

the interviews also showed that Texas differs from many states because legislators are discussing rescission-related reforms. In contrast, Florida was selected as a state with typical insurance laws and regulatory enforcement structures, but where regulators do not believe that consumers lack protections against rescissions, and thus, is not considering reforms related to this issue.

The information presented in this case study was collected primarily through telephone interviews and review of primary source material, including state statutory law, state case law, state regulations, state websites including press release archives, and materials related to the Congressional inquiry.

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 third 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 second presented a summary and analysis of the Texas case study, which served as the precursor for this work.

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 15 years of experience in federal and state health care policy. Hilary Haycock had served as a director at Harbage Consulting and is currently a Health Policy Fellow for Senator Bill Nelson (D-FL). Meredith King Ledford, formerly with the Center for American Progress, is one of the report's three co-authors and advisor to Harbage Consulting. Karen Pollitz, Research Professor at the Health Policy Institute at Georgetown University in Washington, D.C., reviewed and commented on the paper. All errors are those of the authors.

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²³ Since 2005, the Connecticut Insurance Department reports having received just 20 rescission complaints, four of which the department found to be inappropriate. Since the change in state law requiring insurers to request permission to rescind coverage took effect in October 2007, insurers have made just 3 requests. (Letter from Barbara C. Spear, Director, Consumer Services Division, Connecticut Insurance Commissioner, letter to Chairman Henry Waxman, House of Representatives Committee on Oversight and Government Reform.) The Connecticut Insurance Department has reported these data show a decrease in the number of rescissions, but a separate Connecticut Office of the Healthcare Advocate survey of insurers suggested that there were more rescissions following implementation of the 2007 law. (Author email conversation with Victoria Veltri, Counsel for the Office of the Healthcare Advocate, August 17, 2009.)

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Appendix One: California Case Study on Post-Claims Underwriting and Rescission Practices in the Individual Health Insurance Market

Consumer complaints, lawsuits and steady *Los Angeles Times* news coverage of rescissions prompted California's Department of Insurance (CDI), which oversees traditional insurance models, and the Department of Managed Health Care (DMHC), which oversees managed care products, to launch investigations and market-conduct exams in 2006. The Los Angeles City Attorney followed in 2008 with several suits against insurers. In addition, a number of individuals filed lawsuits in 2006 accusing Anthem Blue Cross, the state's largest health insurer, of individual incidents of illegal rescissions and of having systematically identified high-cost patients to retroactively cancel their coverage.¹ As the lawsuits broadened to accuse other large insurers in the state, such as Blue Shield of California, so did the regulatory agencies' investigations.²

However, despite the numerous rescissions revealed by the DMHC and CDI, state regulators do not know how many policies insurers have rescinded in the individual insurance market. In responding to Congressman Waxman's survey in October 2008, CDI indicated that it did not have complete data on the total number of rescissions. For an investigation into rescission practices by the largest insurers in the managed care market, DMHC did compile the total number of policies rescinded by those companies between 2002 and 2006, as seen in California Chart 1 below.

California Chart 1. *Rescissions in the Five Largest Managed Care Plans in California*

Year	Number of Rescissions
2002	882
2003	743
2004	1,436
2005	1,536
2006	302

Source: DMHC, as reported in the California Assembly Committee on Health Analysis of AB 2 (De La Torre) as Amended April 20, 2009. Available at http://info.sen.ca.gov/pub/09-10/bill/asm/ab_0001-0050/ab_2_cfa_20090427_115617_asm_comm.html.

California Regulations

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

California Standards

California's health insurance regulatory structure is divided between traditional health insurance plans, including most preferred provider organizations (PPOs) as well as the few remaining indemnity insurance plans, and managed care plans, which includes health management organizations (HMOs) and some PPOs. Each market is regulated according to its own set of California laws. Traditional insurers are covered by the California Insurance Code, and managed care plans are covered by the Knox-Keene Act in the California Health and Safety Code. Those regulations are enforced by different agencies. Like many states, California elects an Insurance Commissioner to oversee CDI, which

regulates the traditional and PPO market. DMHC is overseen by a director appointed by the Governor and regulates managed care health plans. Many health insurers in the state, including Anthem Blue Cross, Blue Shield, and Health Net, operate both traditional insurance plans regulated by CDI and managed care plans regulated by DMHC.

Although California regulators are required to review the Insurance Code and Health and Safety Code to “ensure consistency in consumer protection,”³ California laws regarding standards for rescission can be inconsistent both internally and with federal HIPAA standards.

Both California’s Health and Safety Code and Insurance Code include sections using similar language directly prohibiting post-claims underwriting or the rescission, cancellation or limitation of coverage, as outlined in California Chart 2.

California Chart 2: *California Laws Banning Post-Claims Underwriting*

Health and Safety Code	Insurance Code
“No health care service plan shall engage in the practice of post-claims underwriting. For purposes of this section, ‘post-claims underwriting’ means the rescinding, canceling, or limiting of a plan contract due to the plan's failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the plan contract.” ⁴	“No insurer issuing or providing any policy of disability insurance covering hospital, medical, or surgical expenses shall engage in the practice of post-claims underwriting. For purposes of this section, ‘post-claims underwriting’ means the rescinding, canceling, or limiting of a policy or certificate due to the insurer’s failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the policy or certificate.” ⁵

However, each code differs in the standard insurers must follow. The Health and Safety Code provides a standard of willful misrepresentation or fraud in two places in the code, both of which appear to be consistent with the HIPAA fraud standard:

“This section [referring to the section banning post-claims underwriting] shall not limit a plan's remedies upon a showing of willful misrepresentation.”⁶

“An enrollment or a subscription may not be canceled or not renewed except for fraud or deception in the use of the services or facilities of the plan or knowingly permitting such fraud or deception by another.”⁷

There are two different and contradictory standards for insurers to follow in rescinding coverage in the California Insurance Code. The HIPAA fraud standard appears in a section guaranteeing the renewability of individual health benefit plans except:

“... for fraud or intentional misrepresentation of material fact under the terms of the coverage by the individual.”⁸

A different section of the Insurance Code appears to contradict this standard and allows such coverage cancellations in more instances than allowed under HIPAA – in the event of fraud (actual intent to deceive) or if information material to the risk posed by the insured was misrepresented:

The falsity of any statement in the application for any policy covered by this chapter shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.⁹

This section of law was cited in the CDI's response to Congressman Waxman's survey question on the state's legal standard for rescissions.¹⁰ In addition, CDI is taking steps in regulations to clarify this further by stating that:

“An applicant's misrepresentation or omission of material health information on the application for health insurance must be of facts known to the applicant and the insurer must ascertain that the applicant appreciated the significance of the information requested.”¹¹

Given the lack of clarity, California courts stepped in, through a 2007 appellate court decision, to set willful misrepresentation or willful omission of material information as the common law standard for rescissions.¹²

At the same time, California insurance has a two-year contestability period,¹³ which could be interpreted to mean that insurers are not required to provide guaranteed renewability as outlined in HIPAA and elsewhere in California state law.¹⁴ It is believed that individuals are more likely to face a rescission during this initial period of coverage.¹⁵ In other words, misstatements that do not meet the standard of fraud may be used as the basis of a coverage rescission or cancellation:

“After two years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for the policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of the two-year period.”¹⁶

California Regulatory Enforcement

CDI and DMHC are responsible for a number of activities related to enforcing state law, including:

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

Consumer Education and Outreach

There are a number of ways California regulators seek to inform individuals about their rights in dealing with their health insurer. While there has been no formal evaluation of these techniques, state officials indicated that they believe the current approach is more effective than those used in the past. It is clear that DMHC is significantly more active in its efforts than CDI.

- **Insurer-to-Consumer Notifications.** In many of their communications with policyholders, insurers and health plans are required to inform consumers of the state agency that regulates their insurance product and how to contact that agency. This information must be provided when the coverage is first issued, when claims are denied, and if coverage is canceled or rescinded.
- **Online Support.** Both state agencies operate websites that provide information about state laws, and how consumers can act on their problems or complaints. DMHC's website is called the HMO Help Center. The websites provide complaint forms, phone numbers for the agency as well as for health plans. Health plans are also required to put information about the state agencies on their own websites.
- **Office of Patient Advocate.** Within DMHC, the Office of Patient Advocate conducts outreach to community groups, including attending community events to distribute information and make presentations.
- **Other Outreach Efforts.** The HMO Help Center has begun a weekly column in local newspapers that offers information on common problems consumers have with their health insurance.

Complaint Tracking System

Like most states, California largely relies on consumer complaints to track what is happening in the market with regards to rescissions. California tracks the number of people covered in the individual market, as well as the companies selling individual insurance policies as a part of the state's financial oversight regulations and to determine fees and assessments. State agencies do not ask insurers to report coverage rescissions or cancellations of private insurance. Relying on complaints is an incomplete system; the recent investigations into insurer behavior were triggered more by media reports and lawsuits than an increase in consumer complaints.¹⁷

Both DMHC and CDI have systems for handling and tracking consumer complaints. Every consumer who contacts either agency with a complaint receives advice on their options and rights. First, consumers are encouraged to go through the internal grievance process must provide policyholder's under state law. If the initial complaint is serious, or if consumers are not satisfied with the outcome of a grievance process, the agency will investigate the complaint and negotiate with the insurance company on the consumer's behalf. The insurer is not required to reach a resolution with the state agency and consumer.¹⁸ Consumers are entitled to pursue legal remedies at any point, including "arbitration under the terms of the insurance contract, a bad faith tort action and/or breach of contract suit."¹⁹

The complaint tracking system records this information, as well as whether or not the agency finds the complaint to be justified. Trends in complaints, whether by geographic location, insurer or complaint subject, can be tracked and used to trigger a market conduct review.

Both state agencies do have the authority to take "administrative action" against entities found to have unlawfully rescinded insurance policies, including imposing fines and penalties.²⁰ While CDI does not have the authority to require coverage reinstatement or to award damages to individuals, DMHC can require a health plan to reinstate coverage and pay health care expenses that would have been covered had coverage not been rescinded. State law allows individuals who believe their managed care coverage has been canceled wrongly to request a review of their case by the director of DMHC.²¹

Market Conduct Reviews

California regulators are statutorily required to conduct regular reviews of insurers regarding treatment of policyholders and compliance with statutes and regulations. Market conduct reviews cover administrative activities such as utilization management, access and availability of providers, and grievance and appeal processes. Insurers are also subject to financial audits and reviews.

Beyond these regular reviews, the DMHC Director and the Insurance Commissioner have significant discretion to perform market conduct reviews and investigate the operations of health insurers. After the rescission cases began coming to light in 2006 through media reports and lawsuits, DMHC and CDI both began investigating the practices of the largest insurers in the individual market. DMHC staff reported that while there were not a large number of rescission cases relative to the size of California's individual market, the "onerous nature" of a coverage rescission to the former policyholder had a high enough impact to warrant such action. The publicity surrounding the early rescission cases in California helped trigger several investigations into the conduct, as can any unusual trend in consumer complaint data. However, such trends do not require market conduct reviews.

Federal Oversight

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. California regulators reported that they did not "interact with the federal government"²² during their investigations or settlement negotiations with insurers around rescission issues.

Changing the System – Recent Work on Rescission and Enforcement

California's regulators and policymakers have been very active in seeking to address the issue of post-claims underwriting and rescissions in state over the past few years. As explained below, legislation, regulation, and the settlements between California's five major health plans and the two regulatory agencies have all changed insurance industry practices.

Administrative Action

DMHC and CDI have taken steps to exercise their regulatory authority to enforce existing state laws around post-claims underwriting and rescissions. Both agencies undertook detailed investigations into the rescission and claims denial practices of five of the largest insurers in the state: Anthem Blue Cross, Blue Shield, Health Net, Kaiser Permanente and PacifiCare. Both CDI and DMHC reached detailed settlements with each, requiring them to change their internal processes. These insurers combined provide coverage for 85 percent of individual insurance market participants, and just those consumers would be affected by the settlement terms. Both agencies reached settlements with the insurers operating in their jurisdiction, resulting in a total of eight rescission-related settlements announced in 2008 and 2009.²³

Each settlement issued similar requirements of insurers that are now being incorporated into regulations for all insurers. The requirements include:

- Designing applications to be unambiguous and clear to average consumers, including questions "designed to solicit accurate health history information" that cover "reasonable time periods;"²⁴
- Conducting medical underwriting in full at the time of application and prior to rescissions, including review of available personal health record information and appropriate follow-up; and

- Creating impartial and transparent grievance procedures, including timely notice to the insured and fair due process protections;
- Requiring insurance agents who help consumers attest to their role in filling out the application;
- Prohibiting compensation or bonuses to employees based on rescissions; and
- Requiring self-audit programs for insurers to ensure ongoing compliance.

DMHC and CDI had originally announced the goal of releasing joint regulations, which would have provided consistent regulatory guidance to insurers in both the traditional and managed care individual markets. The goal of these regulations is to prevent the necessity of rescissions by requiring more complete and accurate medical underwriting at the time of application.²⁵ In June 2009, CDI released a set of draft regulations to apply the same rules to the remaining 15 percent of the marketplace. These regulations are to be finalized by the end of 2009. However, DMHC has since declined to pursue a regulatory approach, stating that a change in law is the preferred route for achieving change.

Legislative Action

California legislators also have taken steps to address the concerns raised by the lawsuits and investigations. A number of bills have been introduced and passed, though few have been signed by the Governor. While bills with the most aggressive steps on insurer oversight were vetoed, others were signed into law that prohibit insurers from offering bonuses to employees based on their efforts to rescind coverage and protect family members from losing their coverage in the event that another family member covered under the same policy had coverage rescinded. The legislation is outlined in California Chart 3.

California Chart 3: *Recent Changes to California Law, Regulations and Insurer Behavior Pertaining to Rescissions*

Legislation	Description	Status
AB 1150 (2007-2008 Session)	Health plans and insurers cannot base employee compensation on the basis of efforts to deny or rescind health coverage.	Enacted
AB 1324 (2007-2008 Session)	Insurers are not allowed to rescind previous authorization of covered medical services that providers have rendered, even if they have rescinded a policyholder's coverage. This protects doctors and hospitals from losing payment for services provided in good faith.	Enacted
AB 2569 (2007-2008 Session)	Health plans and insurers cannot rescind coverage for an entire family covered under a policy if just one member of the family is found to have provided misinformation that can be used as the basis for a coverage cancellation or rescission. The cancellation or rescission will apply only to the individual found to have misrepresented information, and the remaining family members will continue coverage under a revised rate.	Enacted

California Chart 3: (continued) *Recent Changes to California Law, Regulations and Insurer Behavior Pertaining to Rescissions*

Legislation	Description	Status
AB 2 (2009-2010 Session)	<p>Under this bill:</p> <ul style="list-style-type: none"> • Standard information and health history questions for individual market coverage applications, and require regulator review of applications. • Insurers must complete underwriting at the time of application, including reviewing application for accuracy and completeness, reviewing claims information and prescription databases, and working with the applicant to resolve “omissions, ambiguities, or inconsistencies.”²⁶ • Prohibits rescissions or cancellations except in the case of nonpayment or intentional misrepresentations or omissions. • Insurers must report the number of individual insurance policies issued, canceled or rescinded annually. • DMHC and CDI must create an independent process to review insurer decisions to cancel or rescind coverage. 	<p>Passed Legislature, Vetoed by Governor.</p> <p>The Governor vetoed a previous version of this bill in 2008, citing a lack of consumer protections.²⁷</p>
AB 108 (2009-2010 Session)	<p>Would prohibit insurers from rescinding, canceling, limiting or raising the premiums for individual insurance policies after they have been in effect for 24 months. After holding coverage for 24 months, this bill would protect consumers in the event of “any omission, misrepresentation, or inaccuracy in the application form,” even fraud.²⁸</p>	<p>Passed Legislature, Signed by Governor.</p>
AB 730 (2009-2010 Session)	<p>Increases the penalty CDI can impose on insurers for conducting post-claims underwriting “as prohibited by the insurance code” from \$118 to \$5,000 per violation and \$10,000 if the insurer “knew or had reason to know the act was unlawful. This would have put CDI penalties on par with those that can be charged by DMHC.”²⁹</p>	<p>Passed Legislature, Vetoed by Governor.</p>

Appendix Two: Connecticut Case Study on Post-Claims Underwriting and Rescission Practices in the Individual Health Insurance Market

In 2003, the Connecticut Office of the Healthcare Advocate (OHA), an independent state agency, began seeing an increase in complaints from consumers whose coverage had been canceled or rescinded. OHA contacted the state Attorney General (AG), an elected position, as well as the Connecticut Insurance Department (CID), led by an Insurance Commissioner appointed by the governor, and found that those agencies were also experiencing an increase in consumer complaints related to rescissions and cancellations.³⁰

OHA reported that the number of rescission complaints increased to two or three a month and that the consumers who lost their coverage were facing serious medical and financial challenges. OHA led efforts to help consumers but lacked the regulatory authority necessary to determine if rescissions were legal or to reach settlements with insurers. In some of the cases investigated, insurers claimed that rescinded coverage policies were not eligible for the traditional internal appeals process because technically they were considered to never have existed.³¹ The OHA also lacked the regulatory authority to force the insurance companies to share information so it could conduct its own investigations.

CID, which has broad insurance regulatory authority, began an investigation of Assurant, Inc. in 2005. It resulted in a 2008 settlement, which requires the insurer to pay nearly \$1 million in restitution to policyholder and providers for nearly 200 claims improperly denied due to post-claims underwriting.³²

Together, OHA, the AG and CID began pursuing changes to state law to create proscriptive regulations that would help CID limit insurers use of post-claims underwriting to rescind or cancel coverage. This resulted in legislation in 2007 that requires insurers to request permission before rescinding coverage if medical underwriting was not conducted at the time coverage was issued. If underwriting was done, rescissions are not tracked and can be completed without permission. If underwriting was not completed, then the insurer must receive permission and the rescission is tracked.³³ However, there has been some controversy in the way CID has allowed insurers to determine what constitutes medical underwriting. For this reason, OHA has suggested that the way CID collected data following the implementation of the new law in 2007 is not comparable to data collected prior to 2007.³⁴

When asked by Congressman Henry Waxman (D-CA) to provide the number of coverage rescissions in the state, CID relied on the rescission complaints to the Department's consumer complaint logs. Since 2005, CID reports having received only 20 rescission complaints, four of which the department found to be inappropriate.³⁵ Since the change in state law took effect in October of 2007, insurers have made only three requests for rescissions,³⁶ though it is not clear how many rescissions actually have taken place, according to OHA.³⁷

Connecticut Regulations

The laws and regulations in Connecticut are inconsistent with federal standards in guiding insurer underwriting and rescission practices. This section looks at the differences in federal and Connecticut law.

Connecticut Standard

HIPAA allows insurers to rescind or cancel coverage under limited circumstances such as nonpayment of premiums or in the case of fraud — when an individual has made an intentional misrepresentation of material fact.³⁸ Connecticut law directly requires insurers to comply with this federal guaranteed renewability protection:

“Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation and health care center shall comply with sections 2742, 2743, and 2747 of the Public Health Service Act, as set forth in the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) (HIPAA), as amended from time to time, concerning guaranteed renewability of individual health insurance coverage and certification of coverage.”³⁹

Another section of Connecticut law states that coverage may be rescinded on the basis of either intentional misrepresentation, which is consistent with the federal HIPAA standard of fraud, or material omission, which is not:

“The falsity of any statement in the application for any policy covered by sections 38a-481 to 38a-488, inclusive, may not bar the right to recovery there under unless such false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer.”⁴⁰

This means someone can lose coverage for failing to disclose information they “knew or should have known” would impact the insurer’s decision to sell that individual coverage.⁴¹ This standard is significantly broader than the HIPAA fraud standard.

In 2007, Connecticut lawmakers changed state law to increase regulatory oversight of rescissions, with a provision stating that:

“Unless approval is granted . . . no insurer or health care center may rescind, cancel or limit any policy of insurance . . . on the basis of written information submitted on, with or omitted from an insurance application by the insured if the insurer or health care center failed to complete medical underwriting and resolve all reasonable medical questions related to the written information submitted on, with or omitted from the insurance application before issuing the policy, contract, evidence of coverage or certificate.”⁴²

“An insurer or health care center shall apply for approval of such rescission, cancellation or limitation by submitting such written information to the Insurance Commissioner on an application in such form as the commissioner prescribes. Such insurer or health care center shall provide a copy of the application for such approval to the insured or the insured's representative.”⁴³

The insured have the opportunity to submit evidence in their case, which CID must consider in determining if:

“(1) the written information submitted on or with the insurance application was false at the time such application was made and the insured or such insured's representative knew or should have known of the falsity therein, and such submission materially

affects the risk or the hazard assumed by the insurer or health care center, or (2) the information omitted from the insurance application was knowingly omitted by the insured or such insured's representative, or the insured or such insured's representative should have known of such omission, and such omission materially affects the risk or the hazard assumed by the insurer or health care center.”⁴⁴

OHA staff believes that the intent of state law was to require CID regulators to determine if appropriate underwriting had occurred and that rescission was a reasonable response in every instance.⁴⁵ However, CID has limited the scope of such oversight based on a specific reading of the law (repeated from above):

“...if the insurer or health care center failed to complete medical underwriting and resolve all reasonable medical questions related to the written information submitted on, with or omitted from the insurance application before issuing the policy, contract, evidence of coverage or certificate.”⁴⁶

According to CID regulations, if insurers conduct medical underwriting at the time of application and “resolve all reasonable medical questions,” the insurer can rescind coverage without CID approval if the insured provided “false information or falsely omitted information which is material.”⁴⁷ One of OHA’s objections to CID implementation is that it allows insurers to self-regulate. Insurers do not need to prove the falsity of the application to CID to rescind coverage, nor must they prove the completeness of the initial underwriting process to rescind coverage. In fact, CID assumes that short-term policies issued for six months have been medically underwritten.⁴⁸ Only if an insurer has not conducted that underwriting must they demonstrate to CID that a policyholder has a medical condition which would have prevented them from originally issuing a policy. CID is conducting some follow-up with insurers to document compliance with the law. If an insurer is found to not be in compliance with the law, CID can require the insurer to reinstate coverage. Consumers also are allowed to pursue legal remedies.

In addition to requiring CID approval of rescissions, this same 2007 law banned insurers from rescinding or cancelling coverage under any circumstances after the policy had been in effect for two years.⁴⁹ However, most rescissions are believed to occur within the first few years a policy was issued.⁵⁰ For these reasons, OHA pursued legislation in 2009 to improve the oversight of rescissions in the short-term market, but that legislation was vetoed.

Connecticut Regulatory Enforcement

Connecticut insurance regulators share responsibility in enforcing state insurance law and consumer engagement, including:

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

In addition to CID, OHA also is responsible for a significant portion of consumer engagement and outreach and maintains its own complaint tracking and response system.

Consumer Education and Outreach

The Connecticut OHA is primarily responsible for conducting consumer education and outreach on health insurance matters. Representatives from OHA give presentations to community groups, work with providers and disease-specific groups to share information, as well as build coalitions in the community to conduct consumer education. Some of the ways OHA seeks to reach the public is through public service announcements, public service campaigns and advertising on buses and billboards. CID also gives presentations to groups and works with state legislators to reach out to constituents.

Both OHA and CID operate websites and toll-free hotlines which provide information for consumers on their health insurance rights. Consumers can file complaints over the phone, or by filling out complaint forms that can be submitted by mail or electronically. CID recently instituted a new website feature where consumers can “ask a question” of state regulators about their health insurance. This allows consumers to email the department and avoid having to fill out a complaint form or call to speak with a department representative during business hours.

Insurers are also required to provide consumers with information about their health insurance rights, including when claims are being denied or if they are seeking approval for a rescission from CID.

Complaint Tracking and Response

Like most states, Connecticut relies on consumer complaints to track what is happening in the private insurance market. Both OHA and CID have systems to take consumer complaints, investigate the complaint, and work with the insured and insurer to resolve the claim. The OHA tracking system captured the increase in complaints regarding rescissions from Assurant consumers to spark the ensuing settlement and legislative action.

OHA uses its complaint tracking system to monitor trends in the insurance market, and develops annual reports on trends. Complaints are tracked by outcome, the consumer’s clinical condition, and the insurance carrier.

CID complaint data can be tracked by subject of the complaint and carrier, just like OHA complaint data. CID has the regulatory authority to require insurers to reinstate coverage, pay claims and institute fines for violations of state law. In addition, CID staff can undertake market conduct reviews in response to concerns about trends in complaint data, or use that information to make recommendations to the state legislature on how state laws could be improved.

Market Conduct Reviews

CID initiates market conduct reviews for insurers on a regular timetable, generally every three to five years, following NAIC guidance. Regulators do have the discretion to conduct a review for a company sooner than scheduled, as CID did with Assurant in 2005-2007 after concerns about post-claims underwriting were raised. That review resulted in a settlement requiring the insurer to “provide restitution to policyholders who had their claims wrongfully denied based on the alleged existence of a pre-existing condition.”⁵¹ OHA does not have the regulatory authority to carry out market conduct reviews.

A CID report to Congress raises questions about whether their market conduct reviews are capturing information about rescissions. A CID report indicated at least four consumer complaints to the department after 2005 involved inappropriate rescissions.⁵² However, that same report indicated that

market conduct reviews between January 2003 and October 2008 found no violations regarding rescissions.⁵³

Federal Oversight

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. Both OHA and CID reported “no federal involvement”⁵⁴ outside of the Waxman inquiry.

Changing the System – Recent Legislative Work on Rescission and Enforcement

Connecticut regulators are divided on the issue of whether or not the 2007 legislation has been effective at reducing unlawful rescissions in the individual insurance market. CID believes the 2007 legislation has been successful and “has encouraged carriers to be more complete and thorough” in their pre-sale medical underwriting.

OHA has subsequently raised concerns that individuals with short-term health insurance policies were not being protected. Most of those policies are not medically underwritten and are not included under the 2007 law.⁵⁵ OHA pursued legislation in the 2009 session that would have required insurers to receive approval from CID before rescinding short-term policies (with durations of up to one year). Specifically, the insurer would have had to prove to CID that the condition that triggered the investigation was pre-existing and that the insured had made a material misstatement, omission or misrepresentation on their application.⁵⁶ That bill also would have held insurance agents or others assisting in applications “liable for any claims resulting from any information [they] knowingly omitted or misrepresented.”⁵⁷ Although the legislature passed the bill, Governor Rell vetoed it, offering three reasons:

- The 2007 legislation was working. She said “it protects consumers and maintains a viable individual health insurance marketplace.”⁵⁸
- The Governor raised concerns that the new legislation would increase insurance fraud by relieving consumers of liability for providing truthful information to insurers in their applications.
- Finally, the Governor suggested that the bill would have weakened competition in the individual insurance market by creating a disincentive for insurers to sell coverage.

OHA has disputed the Governor’s rationale for vetoing the legislation. For example, OHA asserts that the legislation would protect honest consumers, and for the dishonest ones, “. . . the price of lying is rescission of their policies.”⁵⁹ OHA also suggested that the allegation that the bill would have weakened competition “has no basis in fact” and is based on speculation “that consumers will flock to the market with intent to lie on their applications.”⁶⁰

The Connecticut legislature failed to override Governor Rell’s veto, but OHA plans to try and have the bill reintroduced next session.

Appendix Three: Florida Case Study on Post-Claims Underwriting and Rescission Practices in the Individual Health Insurance Market

State officials in Florida, like many officials in other states, paid close attention to the headlines about rescission practices among insurers in California.⁶¹ These news stories prompted staff in the Florida Department of Financial Services (FLDFS), the regulatory agency with oversight of consumer protections, to look into the practice in the state. Because the state does not require insurers to report rescission rates, FLDFS conducted an internal investigation on the prevalence of post-claims underwriting in the state through the review of consumer complaint records, which the state tracks in the consumer complaint database.⁶²

Most cases of known rescissions tend to be for policies issued in the individual market. These are the policies most likely to be medically underwritten, as risk is concentrated in the applicant and cannot be spread across a group. In Florida, individual insurance includes both policies sold by an in-state insurance company to an individual or a family in the individual market (what most states consider to be individual insurance), as well as coverage offered to individuals as a part of group policies purchased by out-of state associations.⁶³ However, because the master policies for association coverage of individuals are issued outside of Florida, they “are not regulated as strictly by Florida statute.”⁶⁴

In a review of all consumer complaints over a 12-month period in 2007/2008, FLDFS identified more than 2,100 consumer complaints for benefit denials and policy rescissions in all of the state’s health insurance markets.⁶⁵ Most of the complaints in the in-state individual insurance market referred to claims for medical conditions that were excluded from the policy during the underwriting process undertaken at the time of application.

The complaint data in the out-of-state association policies revealed a number of complaints involving post-claims underwriting.⁶⁶ The investigation of complaints against out-of-state carriers showed “no evidence” that insurers were conducting medical underwriting at the time of application but “significant evidence of a general business practice of post-claim underwriting.”⁶⁷

The insurers’ basis for denial of claims and cancellation of insurance in this market was largely due to falsities and misstatements on the application. However, the investigation found that applicants likely misunderstood application questions. In some instances, applications contained “vague and subjective” questions, while in other instances questions covered a period of time that would be “difficult for the average consumer to recall detailed information regarding their medical history.”⁶⁸

Despite the evidence of post-claims underwriting and rescissions in their insurance markets, Florida regulators do not require insurers to report the number of policies rescinded every year. Regulators further declined to request this information from insurers in response to the Waxman data request.⁶⁹

Florida Regulations

FLDFS concluded from its investigation of consumer complaints that “insurance consumers within the State of Florida have limited protections from post-claim underwriting practices when purchasing individual health insurance products.”⁷⁰ The laws and regulations in Florida do not clearly and consistently reflect the federal HIPAA standards in guiding insurer underwriting and rescission practices. Thus, there are cracks in consumer protections in the individual insurance market.

Florida Regulatory Agencies

There are two agencies in Florida with regulatory oversight of health insurers; both have the authority to enforce legal standards in the in-state individual market.⁷¹ The Florida Office of Insurance Regulation (OIR) has the primary responsibility for regulating insurance policy forms and rates and providing financial oversight, including insurance company solvency, market conduct performances and new entrants to the Florida market.⁷² OIR also conducts market conduct reviews.

FLDFS has the primary responsibility over licensing and regulating insurance agents, fraud and consumer complaints.⁷³ Thus FLDFS has jurisdiction over issues related to rescission practices. Within the FLDFS Consumer Services Division, is the Office of the Insurance Consumer Advocate, which seeks to represent consumer interests in insurance issues, including health insurance.

Florida Standards

One section of the Florida State Insurance Statute reflects the HIPAA standard of renewability:

“Except as otherwise provided in this section, an insurer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual...”⁷⁴

This law is consistent with HIPAA by providing the same five exceptions of guaranteed renewability including failure to pay premiums; an act of fraud; if the policy is discontinued for all policyholders; if policyholders move out of the geographic area served by the policy; or if policyholder leaves an association through which they had purchased group coverage. The fraud statute reads as follows:

“The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.”⁷⁵

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

“After 2 years from the issue date, only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred or disability starting after the 2-year period.”⁷⁶

Florida regulators assert that this law provides insurers a two-year period to conduct medical underwriting, during which time consumers pay premiums but do not technically have health coverage.⁷⁷ This is also known as a “contestability period,” during which it may be possible for the insurer to deny claims or cancel coverage at any time. This is inconsistent with guaranteed renewability, as outlined in HIPAA and elsewhere in Florida state law in the first two years of coverage.⁷⁸ Under Florida law, if a policy is lawfully rescinded due to misrepresentation in the application, insurers are required to refund the consumer appropriate amounts of the premium paid thus far.⁷⁹

With some exceptions, Florida state law considers policies sold through out-of-state associations, but which are also individually underwritten, to be “primarily governed by the laws of” the state where the master policy was issued.⁸⁰ The limited regulations Florida applies to these types of policies do not include language regarding guaranteed renewability or contestability of coverage.⁸¹ This indicates Florida regulators may not consider enforcing HIPAA protections in this market within their scope of responsibility. Our research did not explore whether other states would enforce such regulations for Florida residents covered by a policy issued under their jurisdiction.

Florida Regulatory Enforcement

The Florida OIR and FLDFS are responsible for activities related to enforcing state insurance law, including:

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

Consumer Education and Outreach

FLDFS is responsible for consumer outreach and holds regular community meetings and develops public service announcements about consumers' rights.⁸² FLDFS also educates consumers on how to file a complaint or grievance against an insurer, which consumers can do through the FLDFS website, ground mail, electronic mail or the agency's telephone hotline.⁸³ Additionally, FLDFS has conducted "bus tours" of the state, educating consumers about Florida's health insurance laws and consumers' rights.

In the in-state individual health insurance market, insurers are required to notify consumers of their right to appeal if they think their policy has been wrongly terminated or their claim was wrongly denied. FLDFS requires HMOs to notify policyholders of their right to an internal appeals process through their insurer and their right to an external appeals process through FLDFS. In contrast, PPOs must notify consumers only of their internal appeals process. An external appeals process through FLDFS is not available.⁸⁴ FLDFS does not proactively verify whether insurers are adhering to this requirement.

Staff in the Florida State Office of the Consumer Advocate argues that the state's proactive approach to outreach and consumer education explains why there is no evidence of post-claims underwriting or rescission in the in-state individual health insurance market consumer complaint records.⁸⁵ The assumption is that most informed consumers first bring their complaints to their insurer, as Florida law relies on internal insurer review processes and limits consumer access to external appeals. At the same time, however, this could indicate that the state's consumer complaint records may not provide a complete picture of consumer concerns in the individual insurance market.

Complaint Tracking and Response

In 2004, Florida statute was amended to require health insurers to report the "type of major medical policy (individually underwritten), number of policies, and the number of certificates" enforced each year to the Office of Insurance Regulation. There is no requirement for each insurance company to report the number of individual health insurance policies rescinded annually.⁸⁶ Thus, like many states, Florida relies solely on consumer complaint data to track rescissions.

FLDFS tracks and responds to consumer complaints that come through the office via mail, electronic mail, the hotline, or website. Complaints are coded by carrier and by type of complaint. This information is then used to develop weekly reports and discussed in weekly meetings by regulators.⁸⁷ If any concerning trends or patterns are identified, they are referred to the OIR Market Investigation Unit.⁸⁸

Market Conduct Reviews

Florida generally follows NAIC guidelines in determining when to conduct market conduct reviews. These guidelines provide for a regular rotation of health insurer reviews. In addition, any trends in consumer complaint data that indicate to FLDFS an insurer may have a “pattern of violating particular laws” can trigger a market conduct review by OIR.⁸⁹ These reviews include an examination of insurance companies to ensure they are treating policyholders and claimants equitably and that they are in compliance with statutes and regulations.⁹⁰

From January 1, 2003 through November 17, 2008, two market conduct reviews were completed in the state of Florida concerning instances of coverage rescission.⁹¹ One review found that the insurer had not properly refunded premium payments to the rescinded policyholder, but it did not examine the legality of the rescission under Florida law.⁹²

The other rescission-related market conduct review was of an insurer operating in Florida’s out-of-state group insurance market. While some of the complaints reviewed from January 1, 2001 through December 31, 2005 concerned policy rescissions, the examiners did not find the insurer in violation of any Florida statute because the statute that applies to the in-state individual health insurance market is not applicable to the out-of-state group insurance market.⁹³

Role of the Federal Regulators in Florida

Through HIPAA, the federal government has oversight authority of state insurance regulatory practices to ensure enforcement of consumer protections. However, state agencies were unaware of any federal oversight or interaction related to the individual insurance market in Florida.⁹⁴

Looking Ahead – State Action on Rescission and Enforcement

Currently, there is no active effort in the state of Florida to change laws or enforcement practices regarding post-claims underwriting and rescission. At this time, regulators and legislative staff have found the internal investigation of consumer complaints has demonstrated that insurers in the in-state individual health insurance market are adhering to existing Florida regulations and statutes.⁹⁵

State officials have acknowledged that there may be some ways the statutes could be improved. The Office of Insurance Consumer Advocate is planning to draft and advocate for the adoption of legislation in 2010 that would require insurers to use standard, approved underwriting questions in the application for coverage, as well as give the OIR or FLDFS the regulatory authority to review a cancellation decision upon request by the affected policyholder in cases of alleged fraud in the application.⁹⁶ This would be a shift away from the current system where policyholders have limited access to outside appeals processes for resolving complaints against their insurers. Other potential areas of reform identified include the need to increase protection of Florida health insurance consumers in the out-of-state group insurance market, as well as the need to require insurers to report their rate of rescission.⁹⁷

Appendix Four: Texas Case Study on Post-Claims Underwriting and Rescission Practices 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 experience in the individual market. 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 — that is, they reviewed her insurance application against medical records to check for accuracy. After finding a minor discrepancy in her case regarding a doctor's visit for acne, Beaton's insurer canceled her policy.⁹⁸ Beaton was without health coverage and during the five months she had to delay treatment, her tumor tripled in size. Eventually, her health coverage was reinstated after her Congressman, Joe Barton (R-TX), intervened.⁹⁹

The Beaton case, along with headlines about rescission practices among insurers in California,¹⁰⁰ prompted Texas policymakers to proactively investigate the issue. State legislators, such as State Senator Eliot Shapleigh (D-SD 29), and others, including the Texas Medical Association, supported new legislation in the 81st Texas legislative session, which ended in early June 2009, to address insurer practices in the individual insurance market.¹⁰¹

The Texas Department of Insurance (TDI) response to the Congressional survey also helped 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. 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 due to the following reasons:

- 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 one to two 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.¹⁰² If so, then it would be more meaningful to consider the rate of rescission among the smaller subset 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.

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 . . .¹⁰³

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.¹⁰⁴

This may be interpreted as creating a “contestability period.” This would mean that insurers are not required to provide guaranteed renewability as outlined in HIPAA and elsewhere in Texas state law in the first two years of coverage,¹⁰⁵ when individuals are believed to be more likely to face a rescission.¹⁰⁶

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.¹⁰⁷ This standard has been applied to cases where coverage was in effect for fewer than two years.¹⁰⁸ 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.”¹⁰⁹

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 they should contact the Department if their health insurance claim has been denied or if their policy has been rescinded.¹¹⁰ 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. The web site, however, 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 canceled that they have the right to appeal. However, TDI does not verify if this is taking place.¹¹¹ To the extent

there is a notification of rights, consumers likely are receiving the information at a difficult time, as most people facing rescission have recently been diagnosed with a serious illness.¹¹²

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.¹¹³

The Department's complaint inquiry system does collect consumer rescission complaint information. After consumers contact TDI, staff members investigate the concern to determine whether or not the complaint is justified. For rescissions, the investigation seeks to determine if the policyholder intentionally misrepresented his or her medical background on the insurance application. According to TDI staff, intent is sometimes difficult to ascertain, making the issues in a particular case difficult to resolve. At any point, consumers have the right to file a lawsuit for any reason.¹¹⁴

Although the Texas survey of insurers found 6,377 policyholders had their coverage rescinded between 2003 and 2007, consumer complaint files showed that just seven policyholders contacted TDI with a rescission-related complaint in that time period — and only one of those complaints was determined to be justified.¹¹⁵ 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. TDI has never carried out a market conduct exam focused on the rescission issue, but officials indicate that they would “utilize all complaint data, including rescissions, in determining a company's compliance with the law.”¹¹⁶ Regulators have discretion in deciding when to conduct a review. Some occurrences that 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.¹¹⁷

There are no triggers in place that would mandate a market conduct review. The exception is HMOs that must go through a mandated market conduct review every three years.¹¹⁸ 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. It is unclear why 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.¹¹⁹ This is consistent with statements by federal officials.

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 in state law to strengthen and clarify regulations in the individual insurance market. In the most recent legislative session alone, six stand-alone bills were proposed, as outlined in Texas 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.¹²⁰ Additionally, the Texas Association of Health Plans and the Texas Association of Life and Health Insurers supported several of the bills.¹²¹

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

Legislation	Description	Status
<u>Amendment F4 – SB 1007</u>	<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
<u>HB 1748 / SB 1611</u>	<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 canceled benefit plan, but does not protect consumers from this practice. Limits the 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. Did not pass the legislature.</p> <p>SB 1611 – Referred to Senate State Affairs Committee. Did not pass the legislature.</p>

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

Legislation	Description	Status
<u>SB 1257 / HB 2750</u>	<p>This legislation contained the same provisions as HB 1748/SB 1611, as well as 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 department's website. Requires the department of insurance to provide a complaint form on 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. Did not pass the legislature.</p> <p>HB 2750 – Pending in House Insurance Committee. Did not pass the legislature.</p>
<u>SB 206</u>	<p>This legislation 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 department's website. Requires the department of insurance to provide a complaint form on 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> <p>Did not pass the legislature.</p>
<u>SB 207</u>	<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. Did not pass the legislature.</p>
<u>SB 303</u>	<p>This legislation would have required uniform health insurance application questions 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. Did not pass the legislature.</p>

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

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 pre-existing condition exclusion period. 	Referred to House Insurance Committee. Did not pass the legislature.

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."¹²² Since the 81st legislative session ended recently, concrete plans on next steps to pursue these policy changes have not developed. It is probable that Senator Shapleigh and others will file their bills again in the next legislative session.¹²³ In the 82nd legislative session, the legislature will also review the sunset provisions for the Texas Department of Insurance, which did not reinstate TDI under its sunset provision and instead voted to continue the agency temporarily until 2011.¹²⁴

Endnotes

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