



GEORGETOWN UNIVERSITY
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Statement of

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Subcommittee on Oversight and Investigations**

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Good morning Mr. Chairman and Members of the Committee.

I am Karen Pollitz, a Research Professor at the Georgetown University Health Policy Institute, where my colleagues and I study private health insurance and its regulation.

I applaud you for holding this hearing and for the investigation into rescission that preceded it. Rescission of health insurance coverage is a serious issue of utmost importance. It merits close scrutiny not only because of the devastation that coverage loss can cause for individuals, but also for broader lessons that can be learned as you embark on comprehensive health care reform.

Background information about individual health insurance

Rescission is just one problem facing individual health insurance market today. Other problems and weaknesses have been well documented.

In our dynamic system of health coverage, the health insurance status of individuals can change frequently. On average, two million Americans change or lose health coverage each month.¹ Particularly in this economy as layoffs sever access to job-based health coverage, people desperately need to find secure, affordable coverage on their own. The individual market is the place where they turn, but too often this market fails to deliver adequate, affordable, and secure health coverage. In most states individual health insurance is medically underwritten, which means eligibility based on health status. Even slight health problems can trigger denial of an application or an offer of coverage with surcharged premiums or limits on covered benefits. Medical conditions discovered in the course of medical underwriting may be permanently excluded from coverage.²

Coverage under individual policies is typically far less than that provided under employer sponsored group health benefit plans and is often inadequate. Individual health insurance policies are characterized by high cost sharing and the exclusion or limitation of key benefits such as prescription drugs, maternity, and mental health care.³ Coverage in this market is also inefficient with administrative costs accounting for 30 percent or more of premiums, compared to 7 percent for large group health plans.⁴

Rates of turnover in the individual market are also very high. Most policyholders remain enrolled less than two years.⁵ Understandably people who rely on this market while they are between eligibility for job-based or public plans will leave as soon as they can rejoin other subsidized coverage. However, individual market insurers also engage in other practices to discourage people from staying as they age and their health status declines. For example, age rating can surcharge premiums for older policyholders by a factor of three to five, sometime even more. Durational rating applies surcharges at renewal for tenure; healthy policyholders can evade these surcharges by applying for new coverage and re-submitting to medical underwriting, but that option won't work for people who have become sick. Many insurers will also periodically introduce new products on the market and slow or cease marketing of older policies. This is sometimes described as

closing a block of business. Once older products no longer have a steady influx of new, healthy policyholders, the average health status of enrollees rapidly decreases and their premiums begin to spiral, eventually forcing them to drop or decrease coverage.

Making the individual health insurance market work better has, admittedly, presented a daunting challenge. This unsubsidized voluntary market is vulnerable to adverse selection. Many states have been reluctant to apply market reforms, such as guaranteed issue and community rating, to the individual market in the same way that these rules are more often applied to small group coverage. To date, Congress also has declined to apply many incremental reforms to the individual market. However, with the enactment of the Health Insurance Portability and Accountability Act of 1996, Congress did act to apply one important rule broadly to the individual health insurance market – guaranteed renewability.

Federal law guaranteed renewability requirement

Problems of individuals and small employers who had health coverage cancelled in the wake of expensive claims for medical care were widely reported in the 1980s and 1990s.⁶ This was a clear threat to health security that people expected from their insurance coverage. During the health care reform debate of 1993-1994, President Clinton’s plan provided for guaranteed renewability of all health insurance, as did counter proposals put forth by many others.⁷ Calls for guaranteed renewability continued after that national health care reform debate concluded, and in 1996, the protection was included in the federal minimum requirements established for all health insurance by HIPAA. For individual health insurance policies, HIPAA requires

“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.” [emphasis added] Public Health Service Act § 2742(a)

A narrow and specific list of exceptions to guaranteed renewability requirement is enumerated in the law. An insurer may nonrenew or discontinue individual health insurance coverage based only on one or more of the following reasons: (1) nonpayment of premiums, (2) fraud, (3) the insurer discontinues a policy for all policyholders or exits the individual market altogether, (4) the policyholder moves outside the plan’s service area, and (5) in the case of certain association coverage, the policyholder ceases membership in the association.⁸

State laws inconsistent with federal standard

Congress relies on States to adopt and enforce protections at least as strong as federal minimum standards established in HIPAA. Federal fallback enforcement is provided for when states fail to meet this standard.

As States implemented HIPAA they generally adopted the guaranteed renewability rule. However, other conflicting provisions in state law remained unchanged. (See examples in Table 1.) In particular, laws governing so called “contestability periods” continue to

permit insurers to engage in post claims underwriting and to rescind policies or deny claims. State laws regulating incontestability periods create a window - usually two years – when claims made under a policy can be investigated to determine whether they

Table 1. Examples of State laws governing guaranteed renewability and post-claims underwriting

State	Guaranteed Renewability	Incontestability period
AZ	A health care insurer may nonrenew or discontinue the health insurance coverage of an individual in the individual market only for one or more of the following reasons:...The individual has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact under the terms of the coverage. A.R.S. § 20-1380(B)(2)	After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such 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 such two year period." A.R.S. § 20-1346(A)
CA	[Health insurance shall be renewed or continued in force except] for fraud or intentional misrepresentation of material fact under the terms of the coverage by the individual...Cal Ins Code § 10273.6(b)	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 ... Cal Ins Code. § 10350.2(a)
CO	A carrier providing coverage under a health benefit plan shall not discontinue coverage or refuse to renew such plan except for the following reasons:...Fraud or intentional misrepresentation of material fact on the part of the... individual with respect to individual coverage... C.R.S. § 10-16-201.5 (1)(b)	After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred ... C.R.S. § 10-16-202(3)
FL	An insurer may non-renew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following: 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. Fl. Stats. § 627.6425 (2)(b)	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 ... Fl. Stats § 627.607
GA	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. O.C.G.A. § 33-29-21	After two years from the date of issue of this policy and in the absence of fraud, no misstatements made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred ... O.C.G.A. § 33-29-3(a)(b)(A)
MI	...Guaranteed renewal is not required in cases of fraud, intentional misrepresentation of material fact. MCL § 500.2213b (3)	After 3 years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred ... MCL § 500.3408 (a)
PA	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. 40 P.S. § 1302.4	After three years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred ... 40 P.S. § 753 (A)(2)
TX	[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... 28 TAC § 3.3038(c)(2)	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. V.T.C.A., Insurance Code s 1201.208

may be for a pre-existing condition. After the period of incontestability, a policy can be rescinded or a claim denied only on the basis of fraud committed by the policyholder when s/he applied for coverage and was medically underwritten. During this window, however, the fraud-only standard does not apply. Instead, a process of “post-claims underwriting” may be conducted and if any, even unintentional, material misstatement or omission is discovered, consumers may lose their health insurance, despite federal law protections.

Post-claims underwriting

Every health insurer has internal policies and procedures for post-claims underwriting investigations. In general, insurers maintain a list of health conditions and diagnosis codes or other reasons that can trigger a post-claims underwriting investigation. If a new policyholder makes a claim for care related to something on the list, her original application may be pulled for further scrutiny to determine whether information related to the claimed condition was disclosed at the time of application, or whether information about that condition – or any other aspect of her health status at the time of application – may have been misstated or omitted.

How the underwriting process and investigations are handled varies by carrier. Some insurers conduct the initial underwriting process very thoroughly, asking specific questions of applicants, conducting telephone interviews to follow up on information, and even checking medical records and claims that the applicant may have made in the past if they were previously covered by that carrier. All health issues identified during this process are dealt with at the time of application. For example, if the applicant is found to have high blood pressure, she may be offered a policy with a ten percent premium surcharge applied on the basis of that condition. If she accepts that offer and enrolls, her claims related to the high-blood pressure will then be paid.

Other insurers, by contrast, do not underwrite applicants as thoroughly. Underwriting questionnaires sometimes ask broad, vague, or confusing questions that may be difficult for consumers to answer accurately and completely. For example, the application might not ask specifically about high blood pressure, instead asking about “cardiovascular” conditions, which might cause some people with low health literacy skills to misunderstand the question. Even if an application appears unusually “clean” – for example, one submitted by a 62-year-old indicating absolutely no health problems or health history – some insurers might accept that application and conduct no further investigation before coverage is issued, knowing that if a problem has been overlooked, it will be caught later in a post-claims investigation.

Market competition and profit concerns create pressure for medical underwriters to do their job quickly and cheaply, and to rely more heavily on automated systems instead of individual follow up. However the process is conducted, however, if medical underwriting is allowed in health insurance, it should be completed up front, before coverage issued. The recent subprime mortgage scandal – where banks issued mortgages without adequate screening of consumers’ financial status – is analogous. When insurers

issue medically underwritten coverage without carefully screening an applicant's health status and rely on post-claims investigation to avoid incurring a loss, consumers are vulnerable.

Certainly, post-claims investigations will sometimes uncover instances of health insurance fraud. In other reported cases, however, consumers never suspected the coverage they had purchased was anything but secure, and they were devastated when, instead of having claims paid, their health insurance rescinded or terminated.⁹

How extensive is this problem?

Representatives of the insurance industry have testified that rescission is rare and occurs in less than one percent of policies.¹⁰ Even if this estimate is accurate, it is not necessarily comforting. One percent of the population accounts for one-quarter of all medical bills. The sickest individuals may be small in number, but they are the most vulnerable and most in need of coverage.

In addition to a lack of official data on rescissions, there also are not good data on the number of new policyholders who become subject to post-claims investigations or on the other possible outcomes of those investigations, including policy termination, policy "reformation," or imposition of a pre-existing condition exclusion.*

We don't have this information because health insurance industry medical underwriting standards and practices are proprietary. Insurers compete intensely on their ability to avoid risk. Yet, the stakes for people could not be higher. Access to timely and quality health care is directly related to access to health insurance. It is troubling to not know how frequently the problem of health insurance rescission applies, or who is harmed.

At a hearing last summer of the House Committee on Oversight and Government Reform, a representative of the Bush Administration testified that the Centers for Medicare and Medicaid Services (CMS), which is responsible for oversight of HIPAA private health insurance protections, then dedicated only four part-time staff to HIPAA health insurance issues. Further, despite press reports alleging abusive rescission practices, the Agency did not investigate or even make inquiries as to whether federal law guaranteed renewability protections were being adequately enforced.¹¹

Lessons for health care reform

As Members of this Committee undertake broader reform of the health care system, health insurance rescission offers an instructive case study. Consumers will not be helped if the federal government enacts additional rules and protections, but provides no resources to monitor compliance.

* When a policy is "reformed" the original offer of coverage is changed to retroactively impose a premium surcharge, coverage exclusion, or benefit limit.

Under HIPAA, the federal government relies primarily on states to adopt and enforce health insurance protections at least as protective as federal minimum standards. However, at the state level, limited regulatory resources are also an issue. In addition to regulation of health coverage, state commissioners oversee all other lines of insurance. In several states the Insurance Commissioner also regulates banking, commerce, securities, or real estate. In four states, the Insurance Commissioner is also the fire marshal. State insurance departments collectively experienced an 11 percent staffing reduction in 2007 while the premium volume they oversaw increased 12 percent. State regulators necessarily focus primarily on licensing and solvency.¹² Dedicated staff to oversee health insurance and, in particular, health insurer compliance with HIPAA rules are limited. Enforcement of consumer protections is often triggered by complaints.

Complaints-based enforcement is not sufficient; the sickest patients are most vulnerable to problems and may not always have the wherewithal to complain. Instead, more proactive monitoring and enforcement is needed. The black box of health insurance must be made transparent. Health insurers should be required to report regularly on market trends and practices – enrollment, disenrollment, claims payment and denials, and so on – so that regulators can easily track how and where people are covered and how well health insurance protection works. Legislation has been introduced by Representative DeLauro and Senator Rockefeller to establish an Office of Health Insurance Oversight at the Department of Health and Human Services.¹³ The bill provides for detailed reporting of data by health insurers and authorizes additional resources for both the new federal Office and for state insurance departments so that consumer protections can be adequately monitored and enforced.

Mr. Chairman, your investigations have shown that at least one important consumer health insurance protections guaranteed by federal law has not been completely implemented and is not always followed, and people are hurt as a result. With health care reform, Congress will enact further important consumer protections and appropriate hundreds of billions of dollars for health insurance subsidies. As you do this, it will be important to also provide adequate resources for oversight and enforcement at both the federal and state level.

Notes

¹ Short, P, Graefe, D. and Schoen, C, “Churn, Churn, Churn: How Instability of Health Insurance Shapes America’s Uninsured Problem,” The Commonwealth Fund, November 2003.

² Collins, S., et.al., “Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families,” The Commonwealth Fund, September 2006. See also Pollitz, K., Sorian, R., Thomas, K., “How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health?” Henry J. Kaiser Family Foundation, June 2001.

³ Gabel, J., et.al., “Individual Insurance: How Much Financial Protection Does It Provide?” *Health Affairs Web Exclusive*, April 17, 2002, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.172v1.pdf>

⁴ Congressional Budget Office, “Key Issues in Analyzing Major Health Insurance Proposals,” December 2008.

⁵ Kaiser Family Foundation and ehealthinsurance, “Update on Individual Health Insurance,” August 2004.

⁶ See, for example, “A Call for Action” U.S. Bipartisan Commission on Comprehensive Health Care, September 1990.

⁷ See for example, Associated Press, “US Governors Propose Universal Health Insurance,” February 1, 1993. See also description of Senator Dole (R-KS) proposal in “Health care assault on the middle class,” *The Washington Times*, July 26, 1994.

⁸ Public Health Service Act §2742(b)

⁹ Girion, L., “Health insurer tied bonuses to dropping sick policyholders,” *Los Angeles Times*, November 9, 2007. See also testimony of Heidi Bleazard, Committee on Oversight and Government Reform, July 17, 2008. See also testimony of Kevin Lembo, Connecticut State Health Care Advocate, Committee on Oversight and Government Reform, July 17, 2008.

¹⁰ Testimony of Stephanie Kanwit, Hearing on Business Practices in the Individual Health Insurance Market: Termination of Coverage, Committee on Oversight and Government Reform, U.S. House of Representatives, July 17, 2008.

¹¹ Testimony of Abby Block, Hearing on Business Practices in the Individual Health Insurance Market: Termination of Coverage, Committee on Oversight and Government Reform, U.S. House of Representatives, July 17, 2008.

¹² National Association of Insurance Commissioners, *2007 Insurance Department Resources Report*, 2008.

¹³ H.R. 2427 and S. 1050.