Primer on
Post-Claims Underwriting

Peter Harbage M.P.P.
Hilary Haycock
Harbage Consulting

Robert Wood Johnson Foundation

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Following a growing number of anecdotal reports, there is increasing interest in obtaining a better understanding of post-claims underwriting. This "little known business practice"[1] has come to the attention of Rep. Henry Waxman, Chairman of the U.S. House of Representatives Committee on Energy and Commerce, as well as state and federal health insurance regulators. Post-claims underwriting is when an insurer investigates an individual or small group policyholder's medical history after the policy has been issued, and in particular after claims are submitted. Insurers have said that post-claims underwriting prevents fraud and therefore helps keep premiums rates low. For individuals whose health coverage has been canceled after the onset of a serious medical condition, post-claims underwriting can have serious consequences for their health and financial well-being.

Both federal and state laws regulate post-claims underwriting practices, although states are primarily responsible for enforcing those regulations. This varying regulatory enforcement environment creates the possibility for individuals who made good faith premium payments to have their coverage wrongly terminated or rescinded (retroactive cancellation), as has been found in California.[2] The result is that those with insurance face uncertainty over whether it will be there when needed.

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 brief explores what is known and unknown about post-claims underwriting, and state and federal insurance regulations around these issues.

Role of Underwriting

In most states, health insurance in the individual market is medically underwritten. Through underwriting, the insurer will evaluate the risk of each individual applicant to decide whether a policy should be offered and, if so, at what premium. From the insurers' perspective, underwriting protects the insurance pool by preventing adverse selection, which is when those higher risk individuals who believe they may need health coverage are more likely to seek to purchase it. Adverse selection increases costs for all members of an insurance pool, by concentrating risk – and costs – which creates an even stronger disincentive for lower risk individuals to purchase coverage. Indeed, just 20 percent of the American population accounts for 80 percent of medical costs.[3] Medical underwriting helps prevent this by helping an insurer determine:

- *If the applicant is eligible for coverage.* In a few states, and under some conditions, insurance companies are required to accept all applicants, a policy called guaranteed issue. In others, insurers can reject applicants based on their health status.

- *What rate to charge for coverage.* Insurers seek to vary the cost of insurance based on an individual's expected health costs. This is necessary for insurers to both maintain their economic viability and be able to offer insurance to lower risk individuals at rates they will be willing to pay.

- *If there are any coverage limitations to be applied.* Most states allow insurance companies in the individual market to attach riders to insurance policies that exclude certain medical conditions (or body parts and systems) from coverage. Medical underwriting would be used to identify those exclusions.

From the perspective of the applicant, underwriting is a burdensome, and sometimes confusing, process.[4] To determine an individual's risk level, insurers will ask for multiple forms to be completed, previous medical records to be supplied, and sometimes will conduct health exams.[5] There is no national standard for the underwriting process, and state regulations for insurance applications vary. For this reason, the underwriting process likely varies widely, but may include a review of past health claims, applications for individuals to self-report their health status or medical exams.

Post-Claims Underwriting Process and Outcomes

Although the purpose of medical underwriting is to assess an applicant's risk profile before coverage is issued, the process is not foolproof. In some cases, an applicant may have an incentive to conceal information about her health or risk status from an insurer in order to obtain coverage or terms of coverage that might otherwise not be issued. At the same time, an applicant might inadvertently fail to disclose information – for example, about health history in the distant past or concerning seemingly minor and unimportant health conditions or symptoms. Or, an applicant might be unaware of a health condition that is undiagnosed at the time she applies for coverage. It is also possible that insurers may not conduct sufficient medical underwriting at the time they issue a policy.

Preexisting Exclusions

In many states, insurers are allowed to exclude coverage for preexisting medical conditions – or the body parts and systems affected by the condition. The rules for how insurers can determine and impose these preexising condition exclusions (or coverage limitations) are different in the individual market than in the small group market.

Preexisting condition definition: Federal law defines a preexisting condition in the small group market as a condition for which an individual received medical advice, a diagnosis, or treatment in the six months before joining a health plan. In contrast, the definition of preexisting conditions varies by state for the individual market. Eighteen states use the "objective standard" – which is similar to the small group definition – an individual must have received medical attention for the condition. Twenty-four states use the prudent person standard, a higher standard which defines preexisting conditions as any condition for which a prudent person would have sought medical care. This definition includes conditions not yet diagnosed. The remaining 8 states do not even have a definition of preexisting conditions, leaving it to internal insurer determinations.

Look-back periods: Whereas insurers can only use the past six months of an individual's medical history to identify a preexisting condition for any small or large group insurance policy, look-back periods in state individual markets range from 6 months or less in 15 states, to unlimited look-back periods in 13 states.

Exclusion period: In the group market, insurers can only limit coverage for 12 months (or less depending on the size of the group and state regulations), and must give policyholders credit for having continuous prior coverage. In the individual market, 38 states allow insurers to exclude the condition permanently. If the insurer chooses to limit coverage for a period of time, most states limit exclusion periods to 12 or 24 months, with just four states limiting exclusion periods to 9 months or less, and 9 states placing no limit on exclusion periods. Twenty-six states require insurers to give policyholders credit for continuous prior coverage.

SOURCE: Kaiser Family Foundation, State Health Facts, www.statehealthfacts.org

If a new policyholder makes claims for a serious or expensive medical condition during the first year of coverage, the insurer may investigate the claim to determine whether any of these underwriting failures took place. If an insurance company determines through post-claims underwriting that a policyholder has not provided all health information (regardless of the applicant's intent), or that their medical condition was preexisting, it can result in serious financial and coverage consequences for the individual and their family. What action the insurer will take depends not only on the intent of the applicant, but also on the insurer's own internal guidelines on how to act on the results of the investigation and on the content and enforcement of state laws.

- *Coverage Cancellation.* Individuals can find themselves, and possibly their whole family, uninsured. Losing your coverage in this way can make it harder to get new insurance, even from a different company.
- *Coverage Rescission.* A rescission is the retroactive cancellation of health coverage, meaning that not only is an individual's coverage cancelled, but the insurance company is no longer responsible for claims previously submitted. For individuals who have accumulated significant medical bills – the exact claims which prompted the post-claims underwriting – this can be a financial hardship or crisis.
- *Retroactive Coverage Riders.* Alternatively, insurers will sometimes maintain a policyholder's coverage, but will limit that coverage by retroactively imposing an exclusion rider or a rate increase.
- *Preexisting Condition Exclusion.* Insurers may exclude the preexisting medical condition for which the individual needs medical care. This can have the same effect as a coverage cancellation, often interrupting an individual's treatment regimen and resulting in significant medical bills.
- *No Change to Coverage.* Sometimes, post-claims underwriting does not result in any action taken against the policyholder.

Real Life Examples Raise Fairness Concerns

Anecdotal accounts have sparked a recent interest in post-claims underwriting in the major medical health insurance market. Fairness issues arise either if an insurer were to cancel policies simply to improve profits, or if confusing rules create an uneven playing field, biased against the individual. Some examples include:

- *Undiagnosed Preexisting Conditions:* A retiree purchased a series of 6-month short-term insurance policies. Several months after one of these policies went into effect, she went to the doctor regarding a lump that had been behind her ear for about a year. The lump turned out to be cancer, and her insurer canceled her policy on the basis that the lump was preexisting and "an ordinarily prudent person would seek diagnosis or treatment when a lump initially presents itself"[6] – which was prior to the purchase of her current policy.

Post-Claims Underwriting in the Group Market

Post-claims underwriting can happen in the group market. For example, not all states require insurers to cover certain populations, such as step-children or adopted children. Post-claims underwriting can seek to ascertain a policyholder's status, and cancel or rescind coverage for those found to not qualify for coverage. Also, if a health condition was not disclosed during underwriting and that condition would have resulted in a significant increase, the increase might be imposed retroactively or the coverage might be cancelled or rescinded (for the individual who did not disclose information or for the entire group).

- *Omitted Insurance Application Information:* A mother of three who was covered by a policy purchased on the individual market had to have emergency surgery for a perforated ulcer. After the surgery, her insurer asked for more information about her medical history, revealing a past trip to the ob-gyn for heavy menstrual periods which her doctor had assured her were normal. The insurance company rescinded her policy based on this omission, leaving the family with $30,000 in surgery bills.[7]

- *Insufficient Underwriting:* A California woman with endometrial cancer received a hysterectomy, which had been preapproved by her insurer. Her insurer rescinded her coverage for not including her previous bout with breast cancer on her application – even though the breast cancer had occurred 11 years prior and the insurance application only asked for her medical history over the past 10 years. She had asked her insurance agent if she needed to include information about her breast cancer, and he told her no. The patient was left responsible for $160,000 in medical bills.[8]

In response to consumer complaints much like those outlined above, California's Department of Insurance (CA DOI) has required three major insurers – Blue Cross, Blue Shield and Health Net – to restore health coverage which had been wrongfully rescinded for thousands of Californians.[9] Millions of dollars in fines against insurers for misconduct have been levied by both CA DOI and the California Department of Managed Care.[10]

Varying Regulations and Unknown Enforcement Practices Raises Questions

These examples raise important questions about how post-claims underwriting could be better regulated by the states or the federal government. Little research has been done on the oversight of post-claims underwriting – both understanding the patchwork of state protections and how those protections are enforced. Both federal and state governments have some jurisdiction over insurance company practices related to rescissions.

Federal Regulations: HIPAA

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), insurers are required to renew health insurance policies on the individual and group markets. This means in "most cases, that employers or individuals who purchase health insurance can renew the coverage regardless of any health conditions of individuals covered under the insurance policy."[11] The exceptions to guaranteed renewability are: non-payment of premiums; "fraud or other intentional misrepresentation"; if the insurer is leaving the market; if an individual or employer moves out of geographic area of the plan; or, in the case of an association policy, if an individual has left the association contracting with the plan.[12]

State Regulations

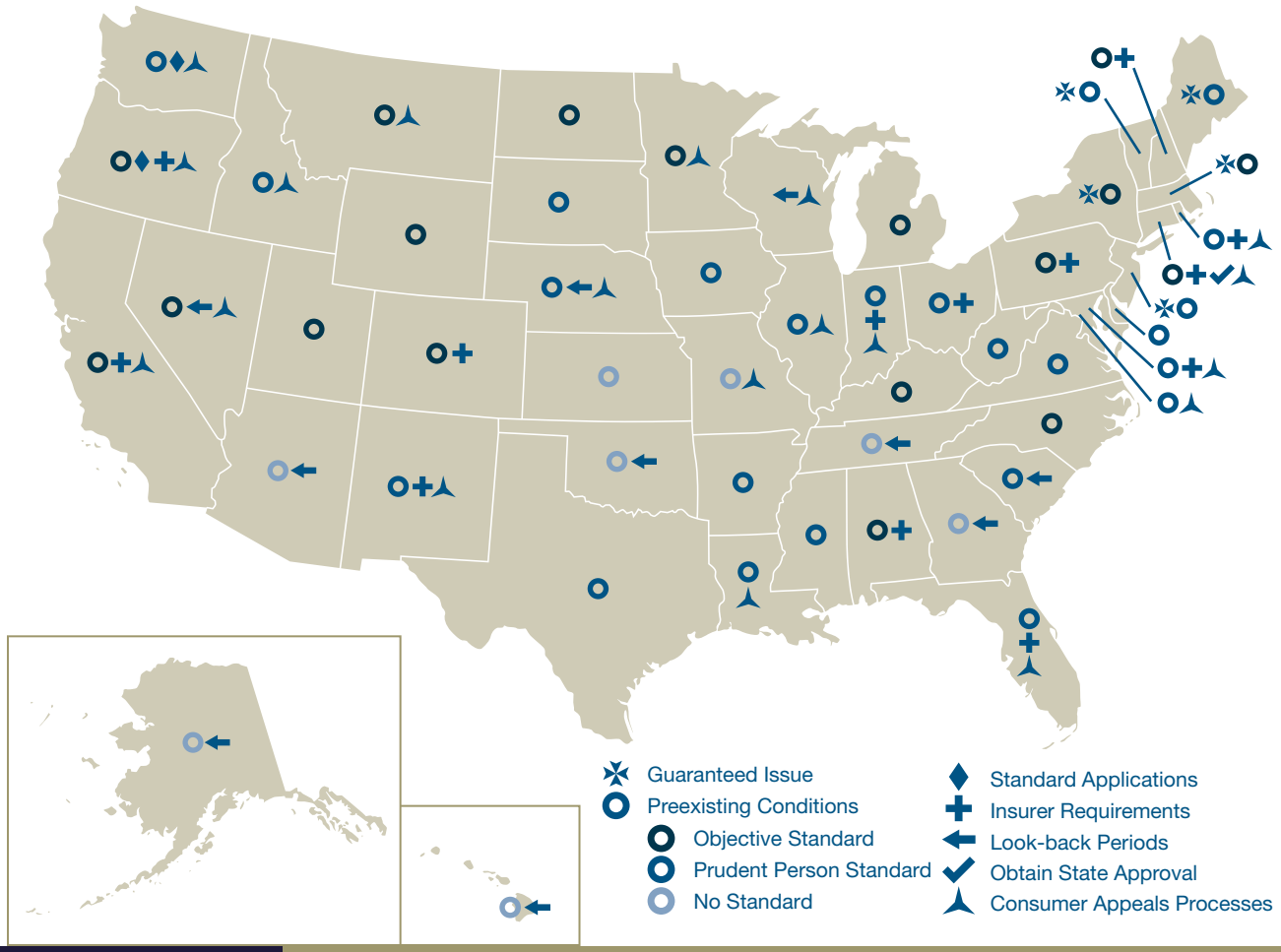
States maintain primary regulatory jurisdiction over health insurance, including post-claims underwriting. The federal HIPAA protections set a floor in consumer protections, but states are allowed to create stronger regulations, as some states have. The following are several types of state regulations around post-claims underwriting:

General Consumer Protection Regulations

- *Guaranteed Issue:* Some states require that any health insurer accept every applicant. As insurers cannot use medical information to condition their acceptance of applicants, they cannot use medical information to cancel or rescind policies later. Just five states offer this regulation for all individual market policies and all residents. (ME, MA, NJ, NY, VT)[13] In other states, guaranteed issue may apply only to qualified applicants (e.g., those who are leaving group coverage and thus are HIPAA eligible) or to certain policies offered by designated insurers (often Blue Cross and/or Blue Shield).

- *Preexisting Conditions:* For policies sold in the individual market, there are three ways that states have generally defined a preexisting condition:

  - » Objective Standard: Only conditions for which an individual has received actual medical care qualifies as a preexisting condition. (AL, CA, CO, CT, KY, MA, MI, MN, MT, NV, NH, NY, NC, ND, OR, PA, UT, WY)
  - » Prudent Person Standard: Any condition that a "prudent person" would have sought coverage for. This standard allows medical conditions which have not been diagnosed or fully manifested to qualify as preexisting (such as the first anecdotal example above). (AR, DE, DC, FL, ID, IL, IN, IA, LA, ME, MD, MS, NE, NJ, NM, OH, RI, SC, SD, TX, VT, VA WA, WV, WI)[14]
  - » No Standard: Some states do not define preexisting conditions in law, leaving to insurers to establish and use their own standards. (AK, AZ, GA, HI, KS, MO, OK, TN)[15]



Regulations Around the Application and Underwriting Process

- *Standard Applications:* Health insurance applications may be long, complex and hard to fill out, which sometimes leads to errors for which individuals have had policies rescinded or cancelled. Some states have tried to require insurers to simplify their applications, or use a uniform application. For example, Oregon insurers are only allowed to use the Oregon Standard Health Statement form, which is 7 pages long, to underwrite the health status of applicants. While Oregon does not allow information about a person's occupation or hobbies to be included, as can be required in other states, the form does require an extensive medical history going back five years. (OR and WA require uniform applications)[16]

- *Insurer Requirements to Complete Medical Underwriting at the Time of Application:* These laws are an attempt to ensure that only those individuals who will be able to keep their coverage receive coverage in the first place. This limits individuals' financial risk of having to pay for medical claims if their insurance policies are rescinded, but may make coverage harder to obtain as well as more expensive. Individuals suspected of fraud would still be subject to rescission or cancellation of their policy under these regulations. (States Which Require Underwriting: CA, CO, CT, FL, IN, MD, NH, NM, OH, PA, RI, WA; States Which Enforce Requirement Without Formal Regulation: AL, NE, OR)[17]

- *Look-Back Periods:* Some states limit how far back into an individual's medical history an insurance company can investigate during medical underwriting. This helps protect individuals from being penalized for conditions which have passed. (No individual market look back limit: AK, AZ, DC, GA, HI, KS, MO, NE, NV, OK, SC, TN, WI)[18]

Regulating the Process After Post-Claims Underwriting

- *State Rescission Standards:* Law standards for rescissions vary by state. Some states allow "material" omissions or misrepresentations as grounds to cancel, reform, or rescind a policy. This means that if the insurer had known the omitted information regarding a person's health status at the time coverage was issued, the underwriting action would have been different. The applicant's intent may not matter if the standard is material omission. Other states use HIPAA standards, which require proof of fraud or intentional misrepresentation in order for a policy to be rescinded or cancelled. While the federal government has oversight authority to ensure that HIPAA guaranteed renewability regulations are enforced at the state level, the federal agency responsible has not reviewed state laws to ensure they reflect those HIPAA rules.[19]

- *Obtain State Approval for Coverage Cancellation or Rescission:* Although just one state currently requires pre-approval of coverage cancellation or rescission. (CT)[20]

- *Consumer Appeals Processes:* States can provide a government-based appeal process if they have lost coverage and believe it was unlawful, or they can require insurance companies to establish a process to do so. (CA, CT, DC, FL, ID, IL, IN, LA, MD, MN, MO, MT, NE, NV, NM, OR, RI, WA, and WI)[21]

(Endnotes)

[1] Waxman, Henry, Opening Statement to U.S. House of Representatives Committee on Oversight and Government Reform Hearing, "Business Practices in the Individual Health Insurance Market: Terminations of Coverage," July 17, 2008.

[2] California Department of Insurance, "Insurance Commissioner Steve Poizner Announces $15 Million Settlement with Blue Cross Over Rescission Practices," News Release, February 11, 2009.

[3] Kaiser Family Foundation calculations using data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), 2006. Calculations located in Kaiser Family Foundation, "Health Care Costs: A Primer," March 2009.

[4] Collins, Sara R., 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.

[5] Kaiser Family Foundation, "How Private Health Coverage Works: A Primer, 2008 Update," April 2008.

[6] Appleby, Julie, "People left holding the bag when policies revoked," *USA Today,* December 13, 2007.

[7] Appleby, Julie, "People left holding the bag when policies revoked," *USA Today*, December 13, 2007.

[8] Girion, Lisa, "Anthem Blue Cross Sued Over Rescissions," *Los Angeles Times*, April 17, 2008.

[9] California Department of Insurance, "Insurance Commissioner Steve Poizner Announces $15 Million Settlement with Blue Cross Over Rescission Practices," News Release, February 11, 2009.

[10] Girion, Lisa, "Anthem Blue Cross Agrees to Take Back Clients, Pay $1 Million Fine" *Los Angeles Times*, February 11, 2009.

[11] Health Care Financing Administration (now known as the Centers for Medicare and Medicaid Services), "Protecting Your Health Insurance Coverage," Department of Health and Human Services Agency, available at http://www.cms.hhs.gov/HealthInsReformforConsume/Downloads/protect.pdf.

[12] The Health Insurance Portability and Accountability Act of 1996, Sections 703, 2712, 2742 and 9803.

[13] Kaiser Family Foundation, State Health Facts, www.statehealthfacts.org.

[14] Ibid.

[15] Ibid.

[16] Families USA, "Post-Claims Underwriting Survey," June 2008 Health Policy Memo.

[17] Ibid.

[18] Kaiser Family Foundation, State Health Facts, www.statehealthfacts.org.

[19] Block, Abby L., "Statement on Rescission of Individual Health Insurance Policies," House Committee on Oversight and Government Reform, July 17, 2008.

[20] Families USA, "Post-Claims Underwriting Survey," June 2008 Health Policy Memo.

[21] Ibid.