

Principles for Ensuring Fair and Appropriate Practices for Individual Market Policy Rescissions and Pre-existing Conditions Clauses

The Board of Directors of America's Health Insurance Plans (AHIP) and its member plans are strongly committed to ensuring appropriate, consumercentric practices in the individual insurance market. We are committed to allowing clear and reliable processes in the rare case where an insurance policy is withdrawn or "rescinded" and for the application of preexisting conditions clauses. When a health insurance plan makes these decisions we support appropriate consumer protections and appeals of these decisions.

Accordingly, health plans need to make the processes for rescissions and for the application of pre-existing conditions clauses clear to consumers. These processes need to be fair, balancing the rights and responsibilities of the health plan, the rights and responsibilities of the consumer, and the rights of the other individuals insured by the health plan.

The purpose of this Appendix is to provide guidance to consumers and health insurance plans regarding their respective rights and responsibilities when inaccurate information is discovered on an application for comprehensive, major-medical-type health insurance and when a health plan makes a decision based on information in such an application.

APPLICATIONS: CONSUMER RIGHTS AND RESPONSIBILITIES

Consumers have the right to apply for individual policy coverage and the responsibility to meet certain requirements when doing so:

1. Consumers should have knowledge of their medical information when applying for a policy. Before completing the application, consumers should review their medical history and should confer, as needed, with any treating physician or other health care provider to ensure that their information is accurate and complete.
2. Consumers should contact the health plan if they have any questions about the information or directions in any materials received from the health plan or from a sales representative.
3. Consumers should take personal responsibility for providing complete

and accurate answers to application questions and, as part of the application process, should sign a statement that they have reviewed all of the information provided. Consumers should *not* assume that the health insurance plan will contact any health care providers identified in the application for additional information.

4. If consumers are in doubt about whether certain information does or does not need to be provided in response to an application question, they should either (1) provide such information on the application, or (2) contact the health plan to ask whether to include the information.

5. Consumers should carefully review and verify all information in the application submitted to the health plan.

APPLICATIONS: HEALTH INSURANCE PLAN RIGHTS AND RESPONSIBILITIES

Health insurance plans have the right to develop plan-specific procedures governing applications, which may differ from plan to plan based on the insurer's internal structure, state law requirements, or other factors. However, all health plans have the responsibility to incorporate the following principles in their insurance application processes:

1. Insurance application questions should be clear and understandable.

2. The application should include a clear statement that information disclosed on the application will be relied upon by the health plan to make a coverage decision. The application should also include clear notification to the consumer of the consumer's responsibility to provide complete and accurate answers, and that failure to do so may result in rescission of the policy.

3. The health plan should provide the consumer with a reasonable opportunity to review the answers to application questions in order to ensure that the answers submitted are complete and accurate, and should provide a toll-free phone number and internet address to assist consumers seeking additional information.

4. Sales representatives and other health plan personnel responsible for providing information and directions to applicants should be trained to instruct applicants to provide complete and accurate answers to all questions on the application, and to take the time necessary to ensure

comprehensiveness and accuracy. Health plans should provide a special toll-free phone number and internet address for questions, comments, or other consumer feedback regarding the accuracy and/or adequacy of information or directions provided by such personnel.

5. In reviewing an application, the health plan should identify any apparently inadequate, unclear, or otherwise questionable information on the application prior to issuing a policy, and should be responsible for obtaining clarification from the consumer prior to issuing a policy.

6. The health plan should rely on written underwriting standards that govern the risk undertaken by the health plan at the time of the application, and should be willing to disclose the reason for an underwriting action to consumers upon request.

RESCISSION AND PRE-EXISTING CONDITIONS EXCLUSION DECISIONS: CONSUMER RIGHTS AND RESPONSIBILITIES

In the event that a health insurance plan seeks to review a policy for rescission or acts to rescind coverage, the consumer should have the right to challenge the rescission, subject to the following responsibilities:

1. Consumers should be responsible for promptly responding to inquiries regarding medical and personal information requested by the health plan during a rescission investigation or review of a claim denial based on a pre-existing medical condition.

2. Consumers should be responsible for following the health plan's procedures for internal appeals and external reviews.

RESCISSION AND PRE-EXISTING CONDITIONS EXCLUSION DECISIONS: HEALTH INSURANCE PLAN RIGHTS AND RESPONSIBILITIES

Health plans have the right to develop and implement plan-specific policies and processes for rescissions and pre-existing conditions exclusions, based on the plan's internal structure, state-law requirements, or other factors, and should incorporate the following principles:

1. The health plan should conduct an objective and thorough investigation prior to initiating a rescission and when reviewing a claim denial based on an exclusion for a pre-existing medical condition.

2. The health plan should limit rescission actions to those based only on

information that should have been included in a complete and accurate response to questions asked in the application. If the health plan failed to conduct a thorough review of unclear or questionable information from the application process, and, based on that review, failed to seek additional information from the applicant, information subsequently obtained by the health plan may not be used as the basis for rescinding coverage.

3. The health plan should limit application of pre-existing conditions exclusions and, if the health plan issues a policy that would otherwise provide benefits for the condition, should provide coverage for a medical condition that is disclosed by an applicant during the application process, unless the condition is the subject of a rider. A health plan could continue to apply current state requirements for pre-existing condition exclusion periods to non-HIPAA eligible individuals who do not provide accurate and complete information about their medical conditions during the application process.

4. The health plan should undertake a rescission investigation within a reasonable time after obtaining the information prompting the need for an investigation; should make reasonable efforts to obtain, in a timely manner, any additional information needed to complete the investigation; and should complete the investigation within a reasonable time after receipt of or efforts to obtain any necessary additional information. The health plan may not rescind a policy while an investigation is in progress.

5. If a health plan, following an investigation, determines that grounds for rescission exist, the plan should:

- notify the customer of the information that has been obtained;
 - explain the specific reasons why coverage may be rescinded;
 - provide a reasonable time period for the customer to respond with additional information;
 - provide clear instructions on how to submit such information;
- and
- keep the customer apprised of delays because of difficulties in obtaining information.

The plan should promptly review such information, if submitted, and should advise the customer regarding the plan's decision to maintain the

policy as issued, reissue the policy subject to revised terms, or proceed with rescission.

6. The health plan's decision to rescind a policy should be based on reliable evidence and should be consistent with the criteria used to initially underwrite the policy. The information on which the health plan seeks to rescind coverage must be material to the risk undertaken by the health plan at the time the policy was underwritten. For example, information about a health condition or treatment arising subsequent to the issuance of the policy may not be used as the basis for, or considered relevant to, a proposed rescission.

7. Health plans should have a full, fair, and clearly stated internal appeal process, and should clearly inform customers of their right to access the process if they wish to dispute a rescission or a claim denial based on a pre-existing medical condition. The process should, at a minimum, include an opportunity to appeal to reviewer(s) distinct from the initial decision maker, and should include review by a medical professional, as appropriate.

RESCISSION AND PRE-EXISTING CONDITIONS EXCLUSION DECISIONS: THIRD PARTY REVIEW OF MEDICAL ISSUES

Health plans should provide consumers with access to a third-party review process to resolve disputes involving medical issues related to pre-existing condition exclusion and rescission decisions.

The third party review process should be established through state legislation that incorporates the following principles:

1. State regulators would screen requests to determine if they are eligible for review (e.g. is there a medical issue in dispute).
2. The third-party reviewer would be independent from both the health plan and the consumer.
3. The review process would include specified timeframes for completing the review, with expedited review available for emergency situations, and would be governed by standards that promote consistency in the decision-making process.
4. The review panel would consist of at least one medical professional and

one attorney.

5. Exhaustion of internal appeal processes before initiation of third-party review and exhaustion of third-party review processes before initiation of litigation would be required.

6. An external review decision favorable to the consumer would be binding on the health plan.

7. If the third-party reviewer upholds the health plan's decision, punitive damages would not be available in any subsequent litigation.

8. In any subsequent litigation, the decision of the third-party review entity would be presumed to be correct and the burden of proof would be on the plaintiff to demonstrate otherwise.

9. If a health plan's decision to rescind a policy is upheld in a third-party review, then the individual would be eligible for coverage in a state guarantee access plan.