



Formerly The Foundation for Taxpayer & Consumer Rights

1750 Ocean Park Boulevard, #200, Santa Monica, CA 90405-4938 • Tel: 310-392-0522 • Fax: 310-392-8874 • www.consumerwatchdog.org

August 4, 2008

The Honorable Henry A. Waxman  
U.S. House of Representatives  
2204 Rayburn House Office Building  
Washington, D.C. 20510

Dear Representative Waxman,

We are pleased to hear that the House Oversight and Government Reform Committee will investigate insurers' practice of canceling health coverage after individual policyholders fall ill and make a claim.

Since 2005, Consumer Watchdog, formerly the Foundation for Taxpayer and Consumer Rights, has closely studied the patient impact and legal nuances of these health insurance rescissions – retroactive cancellations of coverage – and has helped educate the public about the problem. See the attached news clips for a summary of our work.

We write to offer our assistance in your investigation. We also wish to raise four important issues for your consideration.

1. A strong requirement for “intentional misrepresentation” by purchasers of individual insurance that materially affected the insurer’s decision to issue the policy must be enforced.

Rescission is an aggressive remedy and should be reserved for those instances in which a consumer purposefully lied about a known health condition that materially affected the insurer’s decision to issue the insurance policy. Insurers should bear the burden of establishing that a patient intentionally misrepresented a known health condition on his or her application for coverage *before* a rescission is carried out.

As you acknowledged in your opening remarks at the July 17 Oversight and Government Reform Committee hearing, this intent standard is already required under the federal Health Insurance Portability and Accountability Act (HIPPA). Title 42 U.S.C.A. § 300gg-42(b) limits an insurer’s ability to refuse to renew individual policies to instances where a patient committed fraud “or made an intentional misrepresentation of material fact under the terms of the coverage,” failed to pay monthly premiums, or if the plan was terminated or the patient moved out of the coverage area. This and similar state law requirements have been ignored by insurers in California and regulators have failed in their enforcement duties.

To protect innocent patients, intentional misrepresentation must be established prior to *any* rescission, regardless of whether insurers completed medical underwriting to determine an

applicant's insurability prior to issuing the contract. However, insurers argue that they should be allowed to rescind without establishing intentional misrepresentation as long as they complete some medical underwriting prior to issuing the coverage.

Consider the consequences of the insurer's view of the law: A patient applying for health coverage makes an innocent omission on the application by not reporting a possible condition, such as a high blood pressure reading, that the patient's physician *never explained to her*. After submitting the application, the insurer completes some medical underwriting but misses the physician's note in the medical file regarding the patient's high blood pressure. After the coverage is issued, the patient is diagnosed with cancer and the insurer authorizes a doctor to conduct emergency surgery. Once a bill for \$200,000 is submitted to the health plan for payment, the health plan then does another more extensive review of the patient's records and finds the high blood pressure notes. The insurer then rescinds coverage from the day it was issued, stating if they had known about the patient's high blood pressure, the insurer would have never issued the coverage. The patient must then pay the cost of the cancer treatment herself or, as is more likely, declare bankruptcy and possibly not receive treatment.

In addition to the "intentional misrepresentation" standard, under HIPPA insurers are not allowed to rescind coverage unless the insurer can establish that the allegedly omitted information materially affected the insurer's decision to issue the policy. This means that the insurer must establish that the company's underwriting guidelines would have barred the insurer from issuing the insurance policy had the insurer known of the information that the insurer claims was omitted from the application.

However, internal underwriting guidelines of the nation's top health insurers obtained by Consumer Watchdog give insurer underwriters broad discretion to classify many minor conditions as *either* grounds for refusal of coverage *or* for granting coverage with a higher premium cost. Therefore, even if an insurer can show a patient intentionally misrepresented a known health condition, the insurer's remedy should not default to rescission. If the plan would have merely offered the plan at a higher rate, previously rescinded patients should be offered reinstatement of coverage at the higher premium. If the plan fails to meet its burden to prove that a patient would have been refused coverage had the insurer known of the allegedly omitted information, then the default remedy for the patient should be reinstatement of the original policy.

Enforcing the HIPPA material and intentional misrepresentation standards would make the problem of wrongful rescissions largely self-regulating. Insurers would no longer bring "gotcha" actions against patients who never knew of, failed to appreciate the significance of, or forgot some detail of, a past medical problem that the insurer claims was omitted from the patient's application for coverage.

## 2. Reforms must control the increasingly common practice of postclaims underwriting.

Postclaims underwriting—the investigation of a policyholder's insurability only *after* the patient makes a substantial claim—results not only in unjustified rescissions but in other harms that just as effectively lead to patients losing their coverage when they need it most. Many

Americans likely experience this pernicious practice in the form of increased deductibles and premiums, or other limitations of coverage, after they get sick. All such postclaims underwriting is contrary to the basic notion of insurance.

3. Health insurance rescissions must adhere to common law principles of equity.

Rescission is an equitable remedy that should be limited to instances where both parties can be returned to status quo ante, where rescission will bring about substantial justice by adjusting the equities between the parties, and where the rights of third parties, such as doctors, would not be adversely affected.

For example, prior to entering the contract for coverage, patients could have likely been able to obtain coverage from another insurer. However, once patients have become seriously ill they will not likely be able to obtain a policy in any of the forty-plus states that underwrite the individual coverage market. If patients cannot be put back in their position prior to entering the contract, the rescission cannot be carried out.

This brings up the issue of who decides whether the rescission is warranted. As you know, in any other setting, a rescission of a contract requires an adjudication in a court of law. In health insurance, rescission has evolved into a unilateral decision in which the insurer is both judge and jury.

4. New law or regulation must provide a “nexus” requirement.

Finally, there must be a “nexus requirement” to ensure that the rescission relates to the medical problem under review. Patients should not be rescinded when they get cancer for the failure to tell the insurer about their arthritis. Or their blood pressure.

We look forward to discussing these issues with you and the committee in more detail.

Sincerely,



Harvey Rosenfield



Jerry Flanagan