

**United States House of Representatives**  
**Committee on Energy and Commerce**  
**Subcommittee on Oversight and Investigations**  
**July 27, 2009**

Testimony of Carol Cutter, Commissioner  
Indiana Department of Insurance

Chairman Stupak, Ranking Member Walden, Chairman Waxman and Ranking Member Barton, Indiana appreciates the opportunity to discuss rescission of individual health policies in our state.

As you may know, all individual insurance contracts contain certain required provisions that all insurers must include in their form filings submitted to our Department for review, before that contract or policy is allowed to be offered or sold to any consumer residing in Indiana. These provisions have been adopted over the years through our state legislature and tend to be relatively consistent among most all of the 50 states. The National Association of Insurance Commissioners, a trade association that helps state departments of insurance develop language for statutes and regulations, has generated models that states may use for guidance as well.

There are thirteen (13) such provisions in Indiana code. They are 1) entire contract, 2) time limit on certain defenses or incontestability, 3) grace period, 4) reinstatement, 5) notice of claim, 6) claim forms, 7) proofs of loss, 8) time of payment of claims, 9) payment of claims, 10) physical

examinations and autopsy, 11) legal actions, 12) change of beneficiary, 13) guaranteed renewability. Of these provisions, it is the second one that prohibits an insurer from denying a claim or voiding coverage once the policy has been in effect for two years from the date of issue, unless fraud has occurred. This provision, thus, allows an insurer to rescind coverage within the two (2) year window following issuance of the policy for misstatements or pre-existing conditions not indicated on the application for coverage. HIPAA supports this action within the 'guaranteed renewability of individual health coverage' (42 USC 300gg-42) wherein it states an insurer may nonrenew or discontinue coverage due to 1) non-payment of premium, 2) fraud or intentional misrepresentation of material fact, 3) withdrawal of the insurer from writing individual contracts in the marketplace, 4) if the insured moves outside the network service area, and 5) termination of membership in the association that offered the insurance.

There are no provisions in Indiana code specific to 'rescission' or the procedures under which that event is to function. However, Indiana does have a 'waiver' law that allows insurers to offer individual policies that contain exclusions for specific conditions, if the applicant chooses to accept it. Only two (2) waivers per covered person are allowed under the contract, and the exclusion of that condition may not last beyond a maximum of 10 years. This provides an opportunity for more consumers to be approved for individual policies than if the insurers simply declined the applications.

Our policy analysts also review the language contained in any applications used for individual health policies to make certain there are no 'all-inclusive', 'have you ever', or other questions using medical terminology too complex for the average consumer to understand, included. No insurer may use an application without our stamped approval of that form.

Indiana's insurance statutes do not require insurers to report the number of policies rescinded as part of their annual statements. Our involvement with rescissions begins when the insured files a complaint with our Consumer Protection Area and we then investigate the actions surrounding the rescission. Generally, the rescission complaints we've reviewed over the last few years were based upon the same medical condition for which the

insured submitted a claim, but had not revealed that information on the application for coverage. Those insureds who have incurred a rescission may acquire coverage through Indiana's state risk pool, that accepts all applicants who've been refused coverage. The risk pool is subsidized by the insurers and the state.

As noted in prior testimony before this Subcommittee, insurers have established outside review procedures when a rescission occurs, which give the policyholder the opportunity to question those actions, and retain coverage or receive a waiver rider for that condition.

Another concept introduced by the industry has been the change on individual health contracts to a 'guarantee issue' basis, with an accompanying coverage mandate, which would eliminate the need for medical histories for applicants.

Indiana does believe that insurers need to have the ability to perform medical reviews within the two year contestability period so as to protect the majority of policyholders from fraudulent claims payments and higher premiums. We are, certainly, open to discussions as to any improvements that could be made in the rescission process itself.

Thank you for your time. I'll gladly answer any questions you may have.