



Illinois Department of Insurance

PAT QUINN
Governor

MICHAEL T. McRAITH
Director

July 21, 2009

The Honorable Henry A. Waxman
Chairman, Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515-6115

The Honorable Bart Stupak
Chairman, Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515-6115

Re: *H.R. 3200, Rescissions in the Individual Health Insurance Market.*

Dear Chairman Waxman and Chairman Stupak:

On October 31, 2008, the Illinois Department of Insurance (IDOI) submitted information in support of the Committee on Oversight and Government Reform's inquiry into the rescission practices of companies providing individual health insurance in Illinois. In light of your continued examination of the fundamental challenges, if not flaws, of the individual health insurance market, and due to the imperative for broader reforms as now contemplated, we offer this updated information and related comments. Please accept my congratulations and appreciation for your sustained effort on behalf of America's health insurance consumers.

"America's Affordable Health Choices Act of 2009" creatively addresses the most significant challenge for health insurance consumers in Illinois: health status as grounds for underwriting, pricing and coverage denial. While some argue that competitive forces should drive the private insurance market, the truth is that competition for profit will never cover those who are or may become injured or ill.

Rescission-related Complaints

As noted in my prior correspondence, IDOI received 383 rescission-related consumer complaints from 2003-2007. IDOI has since received and investigated fifty (50) complaints from consumers during 2008, and has already received an additional thirty-five (35) complaints in 2009.

The reason that IDOI does not receive more rescission-related complaints, despite Illinois' significant population, is that health insurers operating in Illinois can deny coverage to any individual for any reason that does not disproportionately impact a protected class of residents. Recently, a woman and her children, all in perfect physical health, were denied health insurance in the individual market because the mother informed the prospective insurer that she attended a group grief counseling session after the death of her husband.

IDOI experts thoroughly reviewed the 200 most recent rescission-related complaint files and identified characteristics and findings common to most.

- When underwriting an application for individual health insurance, for purposes of acceptance insurance companies rely on an applicant's self-reported answers to questions about her health status and health history. If a claim is submitted within the policy's initial two-year "contestability period," as allowed under Illinois law, the insurer will initiate an investigation of the applicant's medical history and a close examination of her responses to the health questions on the original application. A company may use even a minor, unintentional or unrelated discrepancy, or purported misrepresentation, as the basis for a policy rescission.
- Some health insurance applications appear constructed to mislead or entrap an applicant into providing incorrect or incomplete responses. The health portions of applications range from 5 broad questions to a list of 125 distinct disorders or conditions. Nearly all applications, however, include at least one question found to be ambiguous and potentially misleading. For example, one consumer's policy was rescinded in part because he responded that he had never "consulted with a physician or medical professional concerning alcohol abuse." Medical records produced by the company indicate that the man was "encouraged" by his physician, during the course of a routine physical examination, to reduce his alcohol intake. This, according to the company, qualified as a "consultation with a physician" concerning alcohol abuse and justified the policy rescission.
- In many cases, the alleged misrepresentation or omission relates to a diagnosis or condition that may not have been known by the policyholder. In one consumer complaint, for example, a woman's policy was rescinded when the company concluded she had failed to disclose an abnormal test result from several years prior. Further examination of the complainant's medical records, however, revealed that she was not notified of this abnormal result in person, but rather via a message left on her home answering machine. Without documentation to verify the content of the message, or that the complainant ever actually received it, the company agreed to reinstate the woman's policy.
- Many of the victims of rescission attributed the alleged incorrect or incomplete response to a miscommunication with, or intentional misrepresentation by, the insurance agent filling out the application. Although the individual applicant must sign the application and is ultimately responsible for its contents, many consumers trust insurance agents and defer to the agent's advice or judgment when deciding how to respond to health questions on an application.
- Forty-three (43) of the 468 rescission-related complaints filed with IDOI since 2003, or 9.2%, resulted in reinstatement of the rescinded policy. Some of the reversals took place only after persistent advocacy by IDOI staff, while others were more readily initiated by the company after new information was presented by the insured, the insured's provider, or the insurance agent.

Illinois' Legal Standard for Rescission

To rescind a health insurance policy in Illinois, a health insurer must show only that "the insured has withheld material information or answered material questions incorrectly on an application which would have resulted in the insurer, at the time of the original application: (1) denying coverage; (2) restricting the level of coverage as applied for; or (3) rating up the premium normally charged for the coverage as applied for" [50 Ill. Admin. Code 2005.40(d)]. The Illinois standard does not require a nexus between any alleged misrepresentation and the actual claim. Rather, current Illinois law vests the insurer with broad discretion and ability to rescind, or to engage in post-claim underwriting that results in the policyholder receiving less coverage than that for which she originally bargained. With such broad discretion, terms such as "withheld" or "answered material questions incorrectly" are subject to multiple interpretations, perhaps dependent upon the nature and cost of the policyholder claim.

Illinois law does not presently establish an evidentiary standard on which any rescission determination is to be based. For example, the insurer can retroactively apply the criteria on which a rescission must be based *and* that insurer can determine information was "withheld" simply based on a purportedly reasonable doubt, or ten percent (10%) of the information.

H.R. 3200 – Necessary Restraints on Rescission

With the passage of much-needed health insurance reform legislation, as proposed in the House Tri-Committee legislation known as "America's Affordable Health Choices Act of 2009," an individual's health status will not remain the shibboleth on which health care is offered. Indeed, when health status loses its current status as an insurer's priority consideration, rescissions should soon become a relic.

However, the Committee should anticipate that health care reform as contemplated in H.R. 3200 will incentivize more insurers, during the interim or transition period, to unload those individuals less likely to be profitable in a modernized health insurance marketplace. A higher legal standard for rescissions during the transition period, as proposed in Section 162 of H.R. 3200, will be necessary to ensure that abusive rescission practices do not increase at the expense or to the detriment of individual policyholders.

Section 162 includes three key elements: (1) fraud requirement; (2) evidentiary standard requiring "clear and convincing" evidence of fraud; and (3) independent, external review of proposed rescissions. Fraud is an appropriately high legal threshold because such a standard includes five essential elements (knowing misrepresentation of a material fact intended to induce reliance and that does induce reliance to the detriment of the insurer) that must be demonstrated by any insurer. In other words, a fraud standard demands a fact-based direct link between the alleged misrepresentation, the insurer's reliance, and the claim submitted.

Section 162 also eliminates the legal ambiguity regarding the evidentiary standard on which a rescission must be based. For example, in Illinois, as mentioned above, a rescission may be based on a "reasonable belief" supported by perhaps ten percent (10%) of the information. By imposing a standard requiring that the alleged fraud be proven by a "clear and convincing" evidentiary standard, the unilateral discretion of the insurer is restricted to facts relevant to the individual claim. Most importantly, the insurer cannot whimsically decide to deny a claim and rescind a policy simply based on an incomplete answer to a confusing question.

Finally, Section 162 subjects all rescission decisions to independent, external review. As a deterrent to insurers, and as a mechanism to impose accountability on insurers, such a process will enhance the

consumer protections needed to ensure individuals and families receive the health care for which premiums have been paid. While tedious and unduly stressful on individuals and families, independent, external review can aid consumers without the financial or personal resources needed to engage an attorney or other private advocate.

"America's Affordable Health Choices Act of 2009" represents a significant step toward modernizing the Illinois health insurance market. Section 162 of the Act, which imposes appropriate rescission protections during the period of transition to a new insurance marketplace, will appropriately restrain this pernicious industry practice and assure our families have access to essential health care.

Please do not hesitate to contact me if you have any questions or would like additional information.

Very truly yours,

A handwritten signature in black ink, appearing to read "Michael T. McRaith". The signature is stylized and cursive.

Michael T. McRaith
Director