



The Council for Affordable Health Insurance's ISSUES & ANSWERS

Solutions for Today's Health Policy Challenges

No. 150

September 2008

Understanding Health Insurance Rescissions

In the last couple of years, news stories have begun to appear in both the local and national press on the ominous-sounding practice known as “rescission,” the termination of an individual (i.e., non-group) health insurance policy based on a substantive misrepresentation, whether intentional or not, on the application.

In most of these stories, the approach is anything but balanced because *insurers cannot legally comment on the case without permission of the insured person*. And that permission is seldom given.

What these news stories fail to recognize is that some people do misrepresent the truth on their application for insurance. Rescission, as a process, protects insurers by allowing them to terminate coverage when the misrepresentation would have changed their underwriting decision. It remains the only remedy insurers can turn to when individuals deceive the insurance company on their insurance applications.

State laws have long recognized rescission as necessary to protect insurers and ensure honest customers aren't penalized with higher insurance rates. Rescissions are rare, and reputable insurers only reluctantly rescind a policy. But consumers also deserve protections that both guarantee the rescission process is fair and the underwriting process is completed in a timely fashion.

How Much Should a Policy Cost? One of the most important questions for health insurers is how much to charge for an insurance policy. The insurer must estimate local and national health care costs, predict health care trends, and evaluate how much risk any given applicant brings to the pool. Too many high-risk applicants could spell financial disaster for the insurer.

This evaluation process is known as underwriting. The health insurer gathers information through an application (which includes numerous medical questions) and often a phone screening.

In assessing an applicant's risk, the insurer faces several problems. Applicants know far more about their own health than the insurance company. They may be aware of symptoms that could signify larger medical problems — symptoms they may choose to minimize or not disclose. Indeed, some people wait until they have an immediate, and often costly, medical need to try to purchase insurance. These problems lead to what's known as “adverse selection,” in which there is a disproportionate number of sick people in the pool.

Once the application process is completed, an underwriter reviews the application in order to evaluate whether or not coverage should be offered, and if so at what price. Vague answers to

medical questions — e.g., “back pain” can mean anything from occasional pain treated with ibuprofen to a chronic degenerative back condition — may require further evaluation, including requesting medical records.

Incontestability Period. Once coverage is issued, the insurance company has no more than two years to investigate any possible misrepresentation on the application. After two years have passed, the insurance company cannot individually terminate coverage except in the cases of nonpayment of premium or fraud (i.e., a higher legal standard such as intentional misrepresentations of serious medical conditions).

Medical History Review. After issuing a policy, health insurers will typically investigate suspicious claims that:

- Seem to indicate a medical condition that began prior to the start of the health insurance policy, and
- Fall within the two-year incontestability period.

In this investigation, usually termed a “medical history review,” the insurer is looking for cases in which the information provided in the application, and received during the underwriting evaluation, was misrepresented. For example, if an insurer receives a medical bill (also known as a claim) for a surgery just days after the policy's effective date, that may indicate an undisclosed pre-existing medical condition.

The claims reviewer will request a copy of the original application and related underwriting materials, medical records from the treating physician, and medical records from any physician listed on the application. The claims reviewer may also request the names and records of all treating medical providers.

Rescission Review. The patient's file is then sent to the insurer's medical department for review. The insurer examines conditions disclosed on the application with those found in the medical records. The insurer must then determine if:

- There was a pre-existing condition and whether it was disclosed on the application;
- The insurer failed to properly investigate any medical conditions disclosed when completing the underwriting process;
- The misrepresentation was material (i.e., would disclosure of the medical condition have changed the original underwriting decision).

Not all misrepresentations lead to rescission. For example, an applicant may misrepresent his weight, claiming to weigh 180 pounds when he actually weighed 185 pounds. Or the applicant may disclose “back pain” but may mean a degenerative back condition. While these would be misrepresentations, the first is not material, and second should have been properly investigated by the insurer. In both of these cases, coverage usually would not be rescinded.

Rescinding Coverage. If the insurer determines the coverage should be rescinded, it will notify the insured person and terminate coverage back to the “effective date,” when the policy was put into effect. The insured person will receive a refund of all premiums less any claims that were paid. Because coverage is terminated back to the effective date of the policy, all other outstanding claims will also be denied by the insurer. How a carrier handles rescission actions may vary, depending upon a state’s laws.

The insured person has the right to appeal the decision to the insurance company and to file a complaint with the state’s insurance commissioner. In many cases, the rescission involves significant outstanding claims and a lawsuit against the insurer may ensue.

Consumer Protections. Consumer advocates have some concerns about the practice of rescinding insurance coverage. Newspaper reports have stoked these concerns but ignore the fact that states have already passed some reforms, including:

- A two-year incontestability period (described earlier);
- Insurance department review of insurer applications — most insurance departments review and approve all insurer documents; and
- Market conduct examinations — insurance departments periodically review insurer operations, including rescission processes.

Bad Solutions. One oft-proposed solution is to severely restrict an insurer’s ability to underwrite in the individual market. That solution may solve the problem of rescissions, but it makes insurance coverage unaffordable for the vast majority of working Americans. A number of states, mostly in the Northeast, passed such reforms more than a decade ago and have virtually destroyed their individual health insurance markets. Some states have recently proposed creating an unreasonable standard that requires the insurer to prove applicants intended to misrepresent their health. Other states have required that all rescission cases be reviewed by the already-overworked insurance department.

Better Solutions. Given the fact that relatively few policies are actually rescinded — an America’s Health Insurance Plans’ survey of its members found a total of 1,900 rescinded policies in 2006 — there are better, common-sense solutions to protect most consumers.

- State regulators should more closely examine insurer applications to guarantee they are both clear and understandable.
- Lawmakers should require that insurer compensation arrangements are never based on claims denials or rescissions.
- Encouraging the use of a personal health record could ensure applicants do not inadvertently misrepresent their health.
- Insurers’ internal processes should ensure that all rescissions are reviewed independently (i.e., not by the original underwriter or by the claims analyst who opened the investigation) before the final decision is made.
- Finally, consumers should be allowed to appeal rescissions to an independent external reviewer as they can for most other claims denials.

Yes, insurers could spend more time reviewing the policies initially, but that takes time and money. And the applicant usually wants the coverage as soon as possible. Asking applicants the relevant questions and relying on their truthful answers is the best way to keep the application process affordable and timely.

Conclusion. Most insurance applicants are honest, but some aren’t. Lawmakers — and the media — need to understand that it isn’t always the applicant who is wronged. Prohibiting rescission would encourage applicants to withhold relevant information, knowing there is nothing an insurer could do after issuing coverage. Such a practice would make insurers more reluctant to issue policies in a timely manner.

The best way to address rescission concerns is to ensure consumers fully understand the application process and receive a fair review of their case if a company rescinds the policy.

Prepared by JP Wieske, State Affairs Director, Council for Affordable Health Insurance

Copyright © 2008. The Council for Affordable Health Insurance

All rights reserved. Reproduction or distribution without the express consent of CAHI is prohibited.

Council for Affordable Health Insurance
127 S. Peyton Street, Suite 210
Alexandria, VA 22314
Phone: 703/836-6200 Fax: 703/836-6550
Email: mail@cahi.org
www.cahi.org