STATE OF CONNECTICUT

INSURANCE DEPARTMENT

BULLETIN HC - 66
September 24, 2007

TO: All Health Insurers and Health Care Centers Authorized To Conduct Business In Connecticut

RE: Public Act No. 07-113 – An Act Concerning Postclaims Underwriting

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Public Act No. 07- 113, An Act Concerning Postclaims Underwriting ("Act") strengthens laws regarding pre-existing conditions for short-term, nonrenewable health policies and policy rescissions, cancellations, and policy limitations for all specified categories of health insurance policies. **The Act is effective to all existing and new policies as of October 1, 2007.**

With respect to rescissions, cancellations and policy limitations, Section 1 of the Act is applicable to individual and group health policies that cover basic hospital expense coverage; basic medical-surgical expense coverage; major medical expense coverage; accident only coverage; limited benefit health coverage; hospital or medical service plan contract; and, hospital and medical coverage provided to subscribers of a health care center. With respect to pre-existing conditions, Section 3 of the Act is applicable to short-term health policies issued on a nonrenewable basis for six months or less. The Insurance Department ("Department") is issuing this bulletin to provide interim guidance in implementing and administering this new law until regulations as authorized by the Act can be promulgated.

Summary

Section 1 of the Act is applicable to policy rescissions, cancellations, and policy limitations for all specified categories of individual and group health insurance policies and provides that:

- No company may rescind, cancel or limit a policy, contract, evidence of coverage or certificate for statements made on, or information omitted from, the policy application if the insurer or health care center failed to complete medical underwriting and resolve all reasonable medical questions related to the written information submitted on, with or omitted from the insurance application before issuing the policy, contract, evidence of coverage or certificate, unless the Insurance Commissioner ("Commissioner") finds that:

  (1) the written information submitted on or with the insurance application was false at the time such application was made and the insured or such insured's representative knew or should have known of the falsity therein, and such submission materially affects the risk or the hazard assumed by the insurer or health care center, or

  (2) the information omitted from the insurance application was knowingly omitted by the insured or such insured's representative, or the insured or such insured's representative should have known of such omission, and such omission materially affects the risk or the hazard assumed by the insurer or health care center.

- The Commissioner will review the request to rescind, cancel or limit based on the information submitted by the companies without requiring a hearing, but if the companies or the policyholders disagree with the Commissioner's decision, they may appeal to the Superior Court.

- The provisions of **Section 1 of the Act** apply when the action contemplated by the insurer or health care center will alter the terms of the originally issued contract or certificate.

The Department is providing this guidance to assist an insurer or health care center in determining if it has, for the purposes of Section 1 of the Act, completed medical underwriting and resolved all reasonable medical questions related to the written information submitted on, with or omitted from the insurance application before issuing the policy, contract, evidence of coverage or certificate.

The Department will consider that an insurer **has** met the statutory Section 1 obligation to complete medical underwriting and resolve all reasonable medical questions related to the written information submitted on, with or omitted from the insurance application, if the application for insurance is completed in full, with responses provided to all questions, and, where required additional and/or clarifying information has been provided in full, the Department believes no further investigation of medical history is required. The Department's position is that an insurer or health care center that has met this obligation under the above criteria, would not be subject to the prior approval process required under Section 1 of the Act **if** it initiates and conducts a review on a post claim basis to obtain information when the information sought is (i) in relation to a medical condition not disclosed on the application or (ii) when the information on the claim or the facts and circumstances of the medical treatment for which a claim is submitted clearly indicate the response or responses to the questions on the application or the information provided on the application might be suspect in any way.

The Department will consider that an insurer **has not** met the statutory Section 1 obligation to complete medical underwriting and resolve all reasonable medical questions related to the written information submitted on, with or omitted from the insurance application **if** the application for insurance is incomplete in any way, such as leaving any inquiries unanswered or not providing additional and/or clarifying information as required, or if the information would be considered as insufficient on its face to permit an insurer or health care center to make a fully informed underwriting assessment and decision with regard to the risk. If the carrier or health care center seeks to perfect the presale underwriting, it can seek additional information, either in the form of a completed application, or medical records as long as that investigation takes place prior to the policy, contract, evidence of coverage or certificate being issued. If no attempt is made to perfect the information, and the policy, contract, evidence of coverage or certificate is issued with no further investigation, any subsequent attempts to rescind, cancel, or limit the policy will require prior approval.

As evidence of proof to both the individual applicant and the Department, insurers[1] will be required to provide notice with any policy, contract, evidence of coverage or certificate issued on or after October 1, 2007 to any applicants for insurance who are accepted for enrollment as to what medical conditions, as noted on their application, will be subject to, and claims denied under, the contractual pre-existing condition limitation. If such notice is not issued, the Department position is that the insurer has not met the statutory obligation to complete medical underwriting and resolve all reasonable medical questions on a presale basis. Separate proof of such notice does not have to be provided to the Department unless a complaint is filed with the Department.

The Department is not mandating the form of the notice; however, a suggested approach may be to provide the notice as part of the cover letter to the issuance of the policy, contract, evidence of coverage or certificate to the accepted applicant. The Department requires that the notice to reasonably inform the individual that the policy contains a pre-existing condition limitation provision and that as a result of the disclosures provided on their application for insurance, the named conditions will not be covered for the period of the contract provision. All conditions for which the pre-existing condition limitation provision will be applied should be identified in such notice.

A claim may be subject to, and denied under, the contractual pre-existing condition limitation only if the above-required notice is provided at issuance. If no notice is provided, the Department will view the contractual pre-existing condition limitation in the contract as having no operable effect for any condition disclosed on the application and thus all claims presented to the insurer based on disclosed information will be paid according to the terms of the insurance contract. If there is a dispute of the contractual determination, the insured continues to have recourse to the usual insurer appeal procedures to contest that determination. The insured may also file a complaint with the Department's Consumer Affairs Division.

If an insurer denies claims under the contractual pre-existing condition limitation for a condition that was disclosed on the application, and for which no prior notice has been issued, the Department will consider that to be a post claim underwriting limitation that required prior approval of the Commissioner if the information pertaining to the pre-existing condition was disclosed on the application. Carriers should note that Section 1 of the Act prohibits not only rescissions and cancellations but also limiting a policy based on written information provided by an insured where the carrier has not completed medical underwriting and resolved all reasonable medical questions in advance of issuing the policy. The Department considers applying a pre-existing condition limitation to be limiting the policy, in violation of the Act, when the insured discloses information on the pre-existing condition on the application and the carrier does not issue a prior notice, as described above, indicating to the insured that the condition will be subject to, and claims denied based on, the pre-existing conditions limitation in the policy. In addition, the Department

[1] Pursuant to Conn. Gen. Stat. §38a-182(b)(4), the Insurance Department does not permit health care center agreements to include an exclusion for pre-existing conditions.

considers an endorsement or rider to a policy excluding a medical condition to be another instance of limiting a policy of insurance and therefore subject to Section 1 of the Act if issued where a carrier has not completed medical underwriting and resolved all reasonable medical questions in advance of issuing the policy.

The Department has learned that, in light of this Act, some insurers/health care centers have stated an intention to change their practices to "pay and chase". This business model calls for the insurer/health care center to issue all policies, contracts, evidences of coverage or certificates without completing medical underwriting or resolving all reasonable medical questions related to the written information submitted on, with, or omitted from the insurance application. The insurer/health care center will pay all claims upon presentment and then investigate and request refunds if the company determines that the claim is related to what the company considers to be a pre-existing condition or that the policy should have been rescinded due to a material omission. The Department believes that "pay and chase" is another version of post-claim underwriting that is prohibited by this Act. If the Department identifies a pattern of "pay and chase" conduct exhibited by any insurer or health care center, the Department will take appropriate administrative action against the insurer or health care center.

Section 3 of the Act strengthens laws regarding pre-existing conditions for **short-term, nonrenewable health policies** and provides that:

- Short-term nonrenewable health policies are now covered under laws dealing with pre-existing conditions and policy rescissions.

- Preexisting conditions limitations and claim denials based thereon are only permitted for the first 12 months following the policy effective date.

- For short-term policies, any pre-existing conditions limitations can only be applied to conditions for which medical advice, diagnosis, care or treatment was recommended or received during the 24 months immediately preceding the coverage effective date.

- The bill extends portability between consecutive short-term policies issued by the same insurer to the same individual. If an insurer issues two consecutive short term health insurance policies on a nonrenewable basis for six months or less which imposes a preexisting conditions provision to the same individual, the preexisting conditions exclusion period in the second policy is required to be reduced by the period of time the individual was covered under the first policy. If the same insurer issues a third or successive policy to the same individual, the preexisting conditions exclusion period must be reduced by the cumulative time covered under the prior policies for all conditions. Consecutive policies are those policies that are issued with a lapse in coverage of no more than 30 days between an earlier policy and a subsequent policy being issued by the same insurer to the same individual policyholder.

- Specific disclosure notices on marketing materials, application and policy forms for short-term policies that alert applicants that pre-existing conditions are not covered are required.

None of these changes mandate that companies will be required to issue or renew short term policies on a guaranteed issue or guaranteed renewal basis. The companies can continue to make the risk acceptance underwriting decisions to accept the applicant, renew the policy, or issue a successive policy as per company underwriting policies.

The Act also provides the Commissioner with the authority to promulgate regulations. The Department is in the process of drafting regulations concerning the rescission protocol; however, in the interim, this bulletin will provide the process and procedures to follow to submit requests for rescission review to the Commissioner upon the effective date of the law.

Prior Approval Process Required Under Section 1 of the Act

Effective October 1, 2007, no insurer or health care center may rescind, cancel or limit any policy of insurance, contract, evidence of coverage or certificate that provides coverage for basic hospital expense coverage; basic medical-surgical expense coverage; major medical expense coverage; accident only coverage; limited benefit health coverage; hospital or medical service plan contract; hospital and medical coverage provided to subscribers of a health care center for statements made on or information omitted from the policy application without receiving the prior approval of the Commissioner if the insurer or health care center failed to complete medical underwriting and resolve all reasonable medical questions related to the written information submitted on, with or omitted from the insurance application before issuing the policy, contract, evidence of coverage or certificate.

Insurers or health care centers who undertake rescissions, cancellations or limitations without obtaining prior approval of the Commissioner on the grounds that the insurer or health care center has completed medical underwriting and resolved all reasonable medical questions related to the written information submitted on, with or omitted from the insurance application before issuing the policy, contract, evidence of coverage or certificate will be required to submit evidence of pre-sale underwriting to the Commissioner should a complaint be filed resulting from rescission, cancellation or limitation.

Requests for rescission, cancellation or limitation must be submitted on the attached form (Application for Rescission or "Application") with all required information provided. Insurers or health care centers seeking rescissions, cancellations or policy limitations are encouraged to provide all relevant information with the submission; information should not be submitted on a selective basis. If the form is not submitted, or an incomplete Application lacking required information is submitted, no rescission, cancellation or limitation may occur. The Department will not try to perfect incomplete Applications; the Department will reject Applications that are incomplete or lacking substantiating information for consideration. The submitting company will be notified that the Application has been rejected as incomplete. The submitting company can resubmit an Application that has been perfected for reconsideration.

Under Section 1 of the Act, no policy or certificate may be rescinded more than two (2) years after the effective date of the policy or certificate.

The insurer or health care center must send a copy of the Application to the insured, or the insured's representative. The Application should be sent to the insured/insured's representative by registered return receipt mail. That return receipt, which evidences the date the copy of the Application was received by the insured/insured's representative must be attached to the Application and submitted to the Commissioner. The Post Office advises that if the addressee refuses to sign the return receipt or if the mail is undeliverable, the entire mail piece will be returned with a reason for non-delivery. If the mail is returned as undeliverable for any reason other than refusal to accept by the addressee, the insurer or health care center is obligated to take reasonable efforts to locate the insured or the insured's representative and to deliver to the most recent address provided to the insurer or health care center by the insured or the insured's representative maintained by the insurer or health care center in its business records prior to submitting the Application. The same diligence used for premium billing/collection purpose is expected for this notice requirement. If the addressee refuses to accept delivery, the returned mail indicating the refusal to accept or the returned mail indicating that the letter was mailed to the most recent address provided to the insurer or health care center by the insured or insured's representative maintained by the insurer or health care centers in its business records must be submitted to the Commissioner and the Application can proceed. This will be interpreted as a refusal to comment by the insured/insured's representative.

The insured/insured's representative has seven (7) business days from receipt (or refusal) of the Application to contact the Commissioner and provide a comment or additional information. The Department will start counting the seven-day comment period from the date on which the insured/insured's representative accepted or refused delivery of the copy of the Application as evidenced by the return receipt. This means that the comment period will have commenced before the date the Application was submitted to the Department. The Department will not act on the Application until the seven-day comment period has expired unless comment is received from the insured/insured's representative before seven days have passed or the notice was refused. If the comment period ends on a non-business day, the period will be extended to the next business day.

The Commissioner is required to issue a determination on the Application not later than fifteen (15) business days after submission of any information submitted by the insured/insured's representative. The Department will start counting the fifteen day period on the first day following receipt of the comments from the insured/insured's representative or the expiration of the comment period, whichever occurs first.

The Commissioner may approve the Application for rescission, cancellation or limitation if the Commissioner finds that:

(1) the written information submitted on or with the insurance application was false at the time such application was made and the insured or insured's representative

knew or should have known of the falsity therein, and the submission materially affects the risk or the hazard assumed by the insurer or health care center, or

(2) the information omitted from the insurance application was knowingly omitted by the insured or insured's representative, or the insured or insured's representative should have known of such omission, and the omission materially affects the risk or the hazard assumed by the insurer or health care center.

The Commissioner's decision to approve or deny the Application will be issued in writing, along with a rationale for the decision, and sent by first class mail to the insurer or health care center, with copies to the insured and the insured's representative. The Commissioner will support the request for rescission, cancellation or limitation if either of the above standards is met.

If the individual or insurer or health care center wishes to contest the Commissioner's decision, an appeal must be made within thirty (30) days after notice of the decision is mailed to the superior court for the judicial district of Hartford. That appeal must be accompanied by a citation to the Commissioner to appear before the said court.

Statutory claim processing timing requirements, pursuant to Conn. Gen. Stat. §38a-816(15), will be tolled from the date the Application is sent to the insured/insured's representative through the date the Commissioner issues his finding. If the Commissioner's decision is contested, the timing requirements will again be tolled during the pendency of the appeal.

Policy Limitation Defined

For purposes of the above, a "policy limitation" is defined as any restriction or revision of the benefits, terms and conditions as stated in the originally proposed or issued policy or certificate, including rate changes resulting from post claim underwriting. This does not include cost sharing or annual maximums that are stated in the originally issued policy or certificate.

HIPAA Implications

A state insurance commission/state insurance department is considered to be a Health Oversight Agency for purposes of the Health Insurance Portability and Accountability Act ("HIPAA"). [2] Pursuant to HIPAA, "Overseeing the health care system" which is included in the definition of health oversight, encompasses activities such as: oversight of health care plans; oversight of health benefit plans;...oversight activities that involve resolution of consumer complaints...access to care, and health insurance coverage for health oversight purposes." Therefore, for HIPAA compliance purposes, state insurance departments are considered to be "Health Oversight Agencies". As such, pursuant to 45 CFR§164.512, there are provisions for

[2] Federal Register Vol. 65, No. 250/Thursday, December 28, 2000/Rules and Regulations (http://www.hhs.gov/ocr/part1.pdf), pages 82491- 82492

which an authorization or opportunity to agree or object to the disclosure by a covered entity of personal health information is not required. This section provides in relevant part as follows:

> A covered entity may use or disclose protected health information without the written authorization of the individual, as described in §164.508, or the opportunity for the individual to agree or object as described in §164.510, in the situations covered by this section, subject to the applicable requirements of this section. When the covered entity is required by this section to inform the individual of, or when the individual may agree to, a use or disclosure permitted by this section, the covered entity's information and the individual's agreement may be given orally.
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> d) *Standard: Uses and disclosures for health oversight activities* —(1) *Permitted disclosures.* A covered entity may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of:
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> (i) The health care system;

Based upon the above, the Department believes no authorizations or consents are required for this disclosure.

Policy Forms

Endorsements or amendatory riders should be submitted to the Department for approval. The notice of specific pre-existing conditions identified through the presale underwriting process is not considered a policy form and therefore does not have to be filed with the Department.

Thomas R. Sullivan
Insurance Commissioner