Act Number:	09-135 Vetoed	
Bill Number:	6531	
Senate Pages:	4546-4552, 4794-4796	**10**
House Pages:	2446-2472	**27**
Committee:	Insurance: 1819-1829, 1860-1868, 1917-1950	**54**
	Page Total:	**91**

S – 590

CONNECTICUT
GENERAL ASSEMBLY
SENATE

PROCEEDINGS
2009

VOL. 52
PART 14
4324 – 4666

Mr. Clerk.

THE CLERK:

Going to Calendar page 8, Mr. President, Calendar 580, Substitute for House Bill Number 55 -- 6531, AN ACT CLARIFYING POSTCLAIMS UNDERWRITING, and the Clerk has amendments.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Mr. President, I move acceptance of the Joint Committee's favorable report and passage of the bill in concurrence with the House.

THE CHAIR:

Acting on acceptance and approval and concurrence with the House would you like to remark further, sir?

SENATOR CRISCO:

Yes, Mr. President. Thank you. Mr. President and members of the circle, I would like to start with House Amendment A, which eliminates the requirement that the insurance commissioner, without the uniform and readable applications for certain individual health insurance and establishes a process for an insurer or HMO to request approval for nonstandard applications. House Amendment A also makes the

insured and producer and agent jointly and severally liable for omissions and misrepresentations under certain circumstances and also changes certain requirements for telephonic applications.

Mr. President and members of the circle, this is a continuation of an issue that we addressed over a year ago in trying to resolve these concerns. This bill limits a health insurer's or an HMO's claim investigation for the purpose of discovering preexisting conditions to those that directly relate to the condition specified in the claim. It removes the requirement that, in order to rescind, cancel, or limit coverage in certain circumstances, an insurer or HMO must have conducted a thorough medical underwriting process for a policy, contract, or certificate that is in effect for less than one year, including short-term health insurance issued on a nonrenewable basis with a duration of six months or less on the basis of written information submitted on, with, or omitted from an insurance application by the insurer.

It maintains the requirement for coverage in effect for at least one year. The deal makes an insurance producer or an agent who completes or helps

to complete an insurance application or does not object to information submitted on, with, or omitted from it., an insured who signs the application,jointly and severally liable for any claims that result from any information knowingly omitted or misrepresented by the producer or agent in the application.

The deal establishes certain notice, deadline and recession requirements for an insurer or HMO that accepts coverage applications over the telephone for individuals' health insurance coverage. It specifies that these requirements do not apply to Medicare supplement bill policies, and it defines certain terms and makes technical and conforming changes.

THE CHAIR:

That's a mouthful. Thank you, Senator Crisco.

Will you remark further?

Senator Prague.

SENATOR PRAGUE:

Thank you, Mr. President. Through you, I want to ask Senator Crisco a question, please.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Yes, Mr. President, that is acceptable.

THE CHAIR:

Please proceed, Senator Prague.

SENATOR PRAGUE:

Senator Crisco, did I understand you to say that this bill deals with preexisting conditions and the denial of coverage based on preexisting conditions, and if that is so, how far back do the insurers go establishing preexisting conditions as a basis for denial?

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Mr. President, through you to Senator Prague, this bill limits a health insurer or HMO's claim investigation for the purpose of discovering preexisting conditions to those that directly relate to the conditions specified in the claim. I believe that it's for preexisting conditions less than a year.

THE CHAIR:

Senator Prague.

SENATOR PRAGUE:

Through you, Mr. President, thank you, Senator Crisco.

THE CHAIR:

Will you remark? Will you remark further on House Bill 6531?

Senator Caligiuri.

SENATOR CALIGIURI:

Thank you, Mr. President. If I may I have a few questions through you to Senator Crisco.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

It's acceptable, Mr. President.

THE CHAIR:

Please proceed.

SENATOR CALIGIURI:

Thank you, Mr. President. My recollection from the hearing on the bill was that the Insurance Department had taken the position that there may not -- and I don't want to put words in their mouth -- really be a need for this bill because the number of complaints represented a very small number, one tenth of one percent of all the complaints received by the department related to this type of an issue.

My question, through you to Senator Crisco, Mr. President, is in light of that testimony from the Insurance Department, why is there a need to make

these additional changes?

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Mr. President, through you to Senator Caligiuri, I believe in working with the health advocate it was discussed that there are situations out there that should be covered in this bill, and you know, I still am of the premise that whether it's one person or a thousand, we have a responsibility to make sure that every policyholder, the one or a thousand, receives appropriate consideration.

THE CHAIR:

Senator Caligiuri.

SENATOR CALIGIURI:

I thank Senator Crisco for that, and I wanted to ask the question, because while I don't believe the bill does any harm, per se, I do think it's important, when we can, to establish the underlying reasoning for making the changes that we're making, especially where there isn't a compelling amount of testimony that there is a significant problem that needs to be solved as is the case with so many of the bills that we pass here. So I thank Senator Crisco for his response.

The fact that we haven't gotten a lot of complaints on it doesn't mean that the system can't be improved yet further. I believe that's Senator Crisco's intention in putting this bill forward, so I will be supporting it, and I thank you, Mr. President.

THE CHAIR:

Thank you, sir.

Will you remark further on House Bill 6531?

Will you remark further?

Senator Crisco.

SENATOR CRISCO:

Thank you, Mr. President. Mr. President, and if there's no objection, I request that it be placed on the Consent Calendar.

THE CHAIR:

There is a motion on the floor by the Senator to place House Bill 6531 on the Consent Calendar. Seeing no objection, so ordered.

Mr. Clerk.

THE CLERK:

Mr. President, continuing on Calendar page 8, Calendar Number 582, Substitute for House Bill Number 5436, AN ACT CONCERNING GUIDE OR ASSISTANCE DOGS AND AUTOMOBILE INSURANCE COVERAGE, as amended by House

S – 591

CONNECTICUT
GENERAL ASSEMBLY
SENATE

PROCEEDINGS
2009

VOL. 52
PART 15
4667 – 5018

SENATOR GAFFEY:

Mr. President, if there's no objection I'd ask that the bill be moved to the Consent Calendar.

THE CHAIR:

The Senator has requested that the bill be placed on the Consent Calendar. Seeing no objection, so ordered sir.

Senator Looney.

SENATOR LOONEY:

Thank you, Mr. President. Mr. President we had one item previously placed on the Consent Calendar that I would move now to remove from the Consent Calendar and to mark it pass temporarily. And that was Calendar page 8, Calendar 582, House Bill 5436.

THE CHAIR:

There's a motion on the floor to remove an item from the Consent Calendar and to PT it. Without objection, so ordered.

SENATOR LOONEY:

Yes, thank you Mr. President. Mr. President, if the Clerk might now call the items on the Consent Calendar.

THE CHAIR:

Mr. Clerk please call Consent Calendar Numero

Uno.

THE CLERK:

Immediate roll call has been ordered in the Senate on the Consent Calendar. Will all senators please return to the chamber. Immediate roll call has been ordered in the Senate on the Consent Calendar. Will all Senators please return to the chamber.

Mr. President the first Consent Calendar begins on Calendar page 1, Calendar 681, House Joint Resolution Number 121; Calendar page 4, Calendar Number 401, Substitute for House Bill 5669; Calendar page 5, Calendar 456, Substitute for House Bill 5019; Calendar page 7, Calendar 532, House Bill 6448; Calendar page 8, Calendar 8 -- correction, Calendar 580, Substitute for House Bill 6531; Calendar page 9, Calendar 597, Substitute for House Bill 6114; Calendar Number 600, House Bill 5635; Calendar page 10, Calendar 605, Substitute for House Bill 6200.

Calendar page 14, Calendar Number 644, House Bill 6391; Calendar 650, Substitute for House Bill 6540; Calendar page 16, Calendar 657, House Bill 6541; Calendar page 29, Calendar 330, Substitute for Senate Bill 954; and Calendar page 34, Calendar Number 504, Substitute for Senate Bill 939.

Mr. President that completes those items placed on the first Consent Calendar.

THE CHAIR:

Mr. Clerk, please call the Consent Calendar again, the machine will be open.

THE CLERK:

The Senate is now voting by roll call on the Consent Calendar. Will all senators please return to the chamber. The Senate is now voting by roll call on the Consent Calendar. Will all senators please return to the chamber.

THE CHAIR:

Have all senators voted? If all senators have voted please check your vote. The machine will be closed. The Clerk will call the tally.

THE CLERK:

Motion is on adoption of Consent Calendar Number 1.

Total Number Voting	36
Those voting Yea	36
Those voting Nay	0
Those absent and not voting	0

THE CHAIR:

Consent Calendar 1 passes.

H – 1044

CONNECTICUT
GENERAL ASSEMBLY
HOUSE

PROCEEDINGS
2009

VOL.52
PART 8
2284 – 2607

DEPUTY SPEAKER MCCLUSKEY:

Have all the Members voted? Have all the Members voted? Will the Members please check the board to determine if your vote is properly cast.

If all the Members have voted, the machine will be locked. The Clerk will take a tally.

Will the Clerk please announce that tally.

CLERK:

House Bill Number 5433.

Total Number Voting	147
Necessary for Passage	74
Those voting Yea	146
Those voting Nay	1
Those absent and not voting	4

DEPUTY SPEAKER MCCLUSKEY:

The bill passes.

Will the Clerk please call Calendar Number 185.

CLERK:

On Page 6, Calendar Number 185, Substitute for House Bill Number 6531 AN ACT CLARIFYING POSTCLAIMS UNDERWRITING. Favorable Report of the Committee on Insurance and Real Estate.

DEPUTY SPEAKER MCCLUSKEY:

Representative Fontana of the 100, excuse me, of the 87th, you have the floor, Sir.

REP. FONTANA: (87th)

Thank you, Mr. Speaker. Mr. Speaker, I move for acceptance of the Joint Committee's Favorable Report and passage of the bill.

DEPUTY SPEAKER MCCLUSKEY:

The question before the Chamber is the acceptance of the Joint Committee's Favorable Report and passage of the bill. Will you remark?

REP. FONTANA: (87th)

Yes, Mr. Speaker, thank you. Mr. Speaker, this bill eliminates the ability of an HMO or insurer, to rescind, cancel or limit coverage under a short-term health insurance policy that is one in effect for less than one year without prior approval of the Insurance Department, based on information a person submitted with or omitted from, his or her insurance application.

Mr. Speaker, this bill builds on Public Act 07-113, which we passed two years ago. At that time we recognized that the short-term health insurance market, in which insurers do not use medical underwriting, was increasing in popularity, but that

in some cases that market had become a breeding ground for conduct such as rescissions and pre-existing condition limitations based on alleged misstatements or omissions from an application.

We intended Public Act 07-113 to reduce the number of rescissions. In practice, however, we are finding that the number of rescissions has not decreased significantly and that the Department is not reviewing the bulk of these decisions because under the Department's interpretation of Public Act 07-113, as long as an insurer in its own judgment has completed medical underwriting, then the insurer can skip over the Department's prior approval process and rescind the policy.

This experience goes against the intent of Public Act 07-113 in several ways. First, short-term policies are not medically underwritten. Medical underwriting involves more as a process used in the short-term market.

Two, the Department has substituted a filled-out form for short-term insurance as completion of medical underwriting.

And three, no company has admitted that it hasn't completed medical underwriting, regardless of the circumstances or the filling out of the application.

According to the Insurance Department, 56 policies, most for short-term insurance were rescinded over the last year and in not one of them did an insurer seek prior approval from the Department. Every insurer, imagine that, stated that it had completed its medical underwriting.

This bill seeks to ensure that insurers after receiving a claim under a short-term health insurance policy, cannot easily rescind the policy through an investigation of the policy's application, rather than resolve the claim satisfactorily.

Its purpose, therefore, is to reduce the ability of insurers to get out from underneath their responsibilities under their policies.

Mr. Speaker, the Clerk has an amendment, LCO Number 6121. I ask that he call and I receive permission to summarize.

DEPUTY SPEAKER MCCLUSKEY:

Will the Clerk please call LCO Number 6121, which will be designated House Amendment Schedule "A".

CLERK:

LCO Number 6121, House "A", offered by Representative Fontana and Senator Crisco.

DEPUTY SPEAKER MCCLUSKEY:

The Representative seeks leave of the Chamber to summarize the Amendment. Is there any objection to summarization? Is there any objection?

Hearing non, seeks leave of the Chamber to summarize the Amendment. Is there any objection to summarization? Is there any objection?

Hearing none, Representative Fontana, you may proceed with summarizing the Amendment.

REP. FONTANA: (87th)

Thank you, Mr. Speaker. Mr. Speaker, this strike-all Amendment makes clarifying revisions to the underlying bill based on an extensive collaboration with the Health Care Advocate, the Insurance Department and industry stakeholders.

Specifically it one, limits the basis of an HMO or an insurer for an investigation based on a suspected pre-existing condition.

Two, holds an applicant and any producer or agent who assists the applicant in completing his or her application, jointly responsible for any information knowingly omitted or misrepresented in an application.

And three, removes a requirement that the Insurance Department develop a standardized application form.

Essentially, Mr. Speaker, this Amendment simplifies the bill, focuses the bill, and ensures that if an insurer seeks to rescind a policy after the policy has been issued, that that insurer goes through a process at the Department to ensure that it is being done fairly, properly and responsibly.

I urge adoption and move adoption of the Amendment. Thank you.

DEPUTY SPEAKER MCCLUSKEY:

Thank you, Sir. The question before the Chamber is adoption of House Amendment Schedule "A". Will you remark? Representative D'Amelio of the 71st, you have the floor, Sir.

REP. D'AMELIO: (71st)

Thank you, Mr. Speaker. Mr. Speaker, I just have a few questions to the proponent of the Amendment.

DEPUTY SPEAKER MCCLUSKEY:

Representative Fontana, prepare yourself. Representative D'Amelio, go forward with your questions, Sir.

REP. D'AMELIO: (71st)

Representative Fontana, when the Amendment is adopted it actually becomes the bill, right?

DEPUTY SPEAKER MCCLUSKEY:

Representative Fontana.

REP. FONTANA: (87th)

Through you, Mr. Speaker, yes, it is a strike-all Amendment. If it is adopted it will become the bill. Through you.

DEPUTY SPEAKER MCCLUSKEY:

Representative D'Amelio.

REP. D'AMELIO: (71st)

Thank you. Representative Fontana, this issue of, I just need to refresh my memory on this, when it came before the Insurance Committee.

Why are we doing this bill? I know that you mentioned that we adopted a law approximately 18 months ago that addressed this issue. What failed in that regard?

DEPUTY SPEAKER MCCLUSKEY:

Representative Fontana.

REP. FONTANA: (87th)

Through you, Mr. Speaker. We are seeking to do this bill because unfortunately, there continue to be every year a number of short-term health insurance

policies, which insurers rescind after the fact, in many cases because they would prefer not to pay the claims brought under the insurance policy.

In essence, Mr. Speaker, short-term insurance is limited in duration and coverage, and therefore it's very inexpensive, and because it needs to be approved and issued very expeditiously.

It is not medically underwritten, which means there is no physical performed on the applicant. The applicant completes an application. Do you smoke? Yes/No. Are you male/female or something else.

You complete the application. You submit it to them with your application fee. It's usually turned around very quickly, and the for a short period of time, usually less than one year, sometimes six months, you have a limited, basic amount of health insurance. And again, it's very inexpensive.

Unfortunately, sometimes after the fact, people discover that they are ill and that they need to have coverage under that plan that can be quite expensive.

Typically, if the care sought is of a very inexpensive nature, there's not a problem. But if you discover that you have cancer, for instance, or another sort of chronic illness, it's very expensive,

the insurance company may decide that it's in its own best interest to investigate your application to try to find either omissions or misstatement that they can use to rescind the policy, negating the coverage that you thought that you were buying at the time that you filled out the application.

So the intent of this bill is to ensure that in those cases, roughly maybe a few dozen a year that usually are quite expensive, the insurer cannot rescind the policy without going through a process at the Department.

In essence, giving the insured, the applicant, the former applicant and the insured, a chance to be heard as to whether in fact there were omissions in the application, whether there were misstatements of fact.

Currently, insurance companies have great latitude to rescind those policies, and the way the act was structured two years ago and the way it's being interpreted by the Department, companies are not affording applicants the opportunity to come before the Department and make their case as to why it was they did not omit material facts, nor did they misstate the facts in the application.

So this is an opportunity for them to essentially hold the insurance companies accountable and not allow them to rescind with little or no oversight by the Department as to that rescission's wisdom or prudence. Through you.

DEPUTY SPEAKER MCCLUSKEY:

Representative D'Amelio.

REP. D'AMELIO: (71st)

Thank you, Mr. Speaker. Thank you, Representative Fontana. A couple more questions to the proponent.

When we talk about short-term policies, Representative Fontana, are we talking six months or less? What is the duration or the intent of this legislation?

DEPUTY SPEAKER MCCLUSKEY:

Representative Fontana.

REP. FONTANA: (87th)

Through you, Mr. Speaker, we're talking about policies of less than one year. Through you.

DEPUTY SPEAKER MCCLUSKEY:

Representative D'Amelio.

REP. D'AMELIO: (71st)

So all policies 12 months or less?

DEPUTY SPEAKER MCCLUSKEY:

Representative Fontana.

REP. FONTANA: (87th)

Through you, Mr. Speaker, the way the language is worded, it appears that it does not apply to policies of one year or more, so when the gentleman says 12 months, I'm just trying to be precise. Twelve months minus one day, less than one year. Through you.

DEPUTY SPEAKER MCCLUSKEY:

Representative D'Amelio.

REP. D'AMELIO: (71st)

Thank you, Mr. Speaker. And the information that's gathered when applying for these policies, does the bill change in any way how the underwriting is done or the information collected by a potential policyholder?

DEPUTY SPEAKER MCCLUSKEY:

Representative Fontana.

REP. FONTANA: (87th)

Through you, Mr. Speaker, I don't believe so. In Subsection (g) Lines 91 through 113, we define the process by which an insurance company shall accept applications. But no, I don't believe we changed the requirements as to what it is that a company has to

collect or what an insurer or an applicant has to provide. Through you.

DEPUTY SPEAKER MCCLUSKEY:

Representative D'Amelio.

REP. D'AMELIO: (71st)

Thank you, Mr. Speaker. I'm interested more in, you know, when they take applications over the telephone. I believe that's what's being addressed in Line 91, Subsection (g), the types of questions that are asked. Are they going to be more pointed questions, more specific questions on, you know, information about pre-existing condition when the application is taken?

DEPUTY SPEAKER MCCLUSKEY:

Representative Fontana.

REP. FONTANA: (87th)

Through you, Mr. Speaker. In the Amendment, Lines 95 through 96 we're requiring the companies to provide additional disclosure as to any pre-existing condition provisions and description of those provisions.

In Lines 96 and 97, we're requiring disclosure of relevant exclusionary periods pertaining to pre-existing conditions. So we are certainly in those

lines increasing the disclosure, the information that the insurer must provide to the applicant, but I don't believe we are changing in any way the questions that the insurer would have to ask the applicant. Through you.

DEPUTY SPEAKER MCCLUSKEY:

Representative D'Amelio.

REP. D'AMELIO: (71st)

Thank you. Through you, so we're not really changing the form of questions. We're not asking for more specific, more general information? Through you.

DEPUTY SPEAKER MCCLUSKEY:

Representative Fontana.

REP. FONTANA: (87th)

Through you, Mr. Speaker, no, we are not. We may have entertained that at the time we had the public hearing, but we had discarded that notion as micromanaging, inappropriate, unnecessary and unreasonable.

Through you.

DEPUTY SPEAKER MCCLUSKEY:

Representative D'Amelio.

REP. D'AMELIO: (71st)

Thank you, Mr. Speaker. One more question for legislative intent, just so I could understand it also.

When the application is taken and processed, does the applicant, does the company have to send through the mail the application, the information, like you know, monthly premium, duration of policy, pre-existing conditions to an applicant that did not get approved?

Through you, Mr. Speaker.

DEPUTY SPEAKER MCCLUSKEY:

Representative Fontana.

REP. FONTANA: (87th)

Through you, Mr. Speaker. The language in Subsection (g) pertains to insurers or healthcare centers that accept a telephonic application.

Certainly the legislative intent is not our intent, Mr. Speaker, that insurers shall have to provide applicants with copies of their applications if they reject or decline the application. That seems to be unreasonable.

The intent is to provide it to applicants who are approved or accepted for insurance. Through you.

DEPUTY SPEAKER MCCLUSKEY:

Representative Fontana. Representative D'Amelio. Sorry, Sir.

REP. D'AMELIO: (71st)

Thank you, Mr. Speaker. One more question, through you, Mr. Speaker. Do we have a number, since Public Act 07-113 was enacted a couple years ago, or 18 months ago concerning this issue, do we have a number of how many of these short-term policies came under scrutiny by the Department?

DEPUTY SPEAKER MCCLUSKEY:

Representative Fontana.

REP. FONTANA: (87th)

Through you, Mr. Speaker, I do not have that information, other than the information I provided in my opening remarks, which is that no policies have been brought to the Department for their prior approval for rescission, so beyond that I do not have information as to how many may have been brought to the Department.

Through you.

DEPUTY SPEAKER MCCLUSKEY:

Representative D'Amelio.

REP. D'AMELIO: (71)

Thank you, Mr. Speaker. No further questions, Mr. Speaker. I unfortunately will be opposing this legislation today, Mr. Speaker. I really don't see a need for us to change the law in the State of Connecticut that was passed 18 months ago.

As a matter of fact, what we did 18 months ago with postclaim underwriting became landmark legislation that other states, California, Maryland, for example, have adopted.

The testimony before the Insurance Committee pretty much proved that there really is no need in my mind, to change the legislation. I believe that there isn't really a problem that exists out there today in this area, so I oppose the legislation. Thank you, Mr. Speaker.

DEPUTY SPEAKER MCCLUSKEY:

Thank you, Sir. Will you remark further on House Amendment Schedule "A"? Will you remark further on House Amendment Schedule "A"?

If not, I'll try your minds. All those in favor of House Amendment Schedule "A", oops. Excuse me. Representative Miner. You called me at the last minute. Go ahead, Sir.

REP. MINER: (66th)

Thank you, Mr. Speaker. I apologize. If I might, a few questions, through you to the proponent of the Amendment, please.

DEPUTY SPEAKER MCCLUSKEY:

Representative Fontana, prepare yourself, Sir. Representative Miner.

REP. MINER: (66th)

Thank you, Mr. Speaker. Through you, Mr. Speaker, I'm trying to understand this process as it's laid out in the Amendment and I'm imagining that there's something that's occurred where an individual filled out an application, submitted it to an insurance company, after a period of time claims were made on that and the insurance company said, wait a minute.

The coverage for which you're seeking, the claims for which you're seeking coverage might have pre-existed, meaning the illness may have pre-existed the coverage date and the application date.

Is that correct? Through you, Mr. Speaker.

DEPUTY SPEAKER MCCLUSKEY:

Representative Fontana.

REP. FONTANA: (87th)

Through you, Mr. Speaker, that's one of the two cases. Again, what typically happens is, either as an insurer seeks to, it's in the policy because it believes that there may be a pre-existing condition and/or that there may have been omissions or material misstatements by the applicant and the insurer. Through you.

DEPUTY SPEAKER MCCLUSKEY:

Representative Miner.

REP. MINER: (66th)

Thank you, Mr. Speaker. And through you, in the case of an omission in terms of a pre-existing condition, if an individual had a pre-existing condition that they knew would not be covered if it was disclosed, under this circumstance, would the insurance company be on the hook for the claims resulting from treatment of that pre-existing condition? Through you.

DEPUTY SPEAKER MCCLUSKEY:

Representative Fontana.

REP. FONTANA: (87th)

Through you, Mr. Speaker, no. Pre-existing conditions, again, under the language in Subsection (g), the company will state very clearly its pre-

existing conditions, limitations or exclusions and there is no requirement that pre-existing conditions be covered under these policies, so it seems to me the applicant and/or the agent, would be on the hook for omitting or materially misstating the facts of his or her health prior to applying. Through you.

DEPUTY SPEAKER MCCLUSKEY:

Representative Miner.

REP. MINER: (66th)

And thank you. And under the Amendment, then, if the insurance company felt that there was a case where something had been intentionally omitted, the Insurance Commissioner would have to provide authorization to rescind prior to them not making coverage? Is that how this Amendment's drafted? Through you, Mr. Speaker.

DEPUTY SPEAKER MCCLUSKEY:

Representative Fontana.

REP. FONTANA: (87th)

Through you, Mr. Speaker, it creates a process at the Department by which a company that would seek to rescind or cancel a policy would have that proposed rescission reviewed by the Department.

In essence, it affords both the insurer and the insured an opportunity to make his or her, or their case as to whether there was or was not a pre-existing condition and/or an omission or material misstatement prior to applying. Through you.

DEPUTY SPEAKER MCCLUSKEY:

Representative Miner.

REP. MINER: (66th)

Thank you. And throughout that process, is it anticipated that the insurance company would remain responsible until it was determined by the Department of Insurance that it's all right to rescind?

Through you.

DEPUTY SPEAKER MCCLUSKEY:

Representative Fontana.

REP. FONTANA: (87th)

Let me review the existing language of the statute, if I may, Mr. Speaker.

Through you, Mr. Speaker, the underlying statute seems to be silent as to that matter, so I would believe that they would be responsible pending the, the insurance company would be responsible pending the outcome of the hearing to rescind. Through you.

DEPUTY SPEAKER MCCLUSKEY:

Representative Miner.

REP. MINER: (66th)

Thank you, Mr. Speaker, and that's how I read it as well. I guess my point is, I don't know how long this process is anticipated to run.

Is there a finality by which the agency has to conclude its investigation and make a determination that it's all right for the insurance company to rescind coverage? Through you, Mr. Speaker.

DEPUTY SPEAKER MCCLUSKEY:

Representative Fontana.

REP. FONTANA: (87th)

Through you, Mr. Speaker, if you look at the, if the gentleman will look at the Amendment, and specifically those sections of the underlying law, which we are not changing, specifically Lines 46 through 71, which is currently Subsection (b), which we would rename Subsection (d) and 83, 90, which are existing Subsection (c), which we would rename Section (f), it details specifically the timeframe for which an appeal would be taken.

For instance, in Line 51, not later than seven business days.

Line 55, not later than 15 business days.

In Line 82, not later than 30 days, so the existing law, whether amended or not, specifies the timeframe that would apply. Through you, Mr. Speaker.

DEPUTY SPEAKER MCCLUSKEY:

Representative Miner.

REP. MINER: (66th)

Right. And so in this case, through you, what's at play here is, that while the clock is ticking, there's no question that the insurance company is on the hook until the Insurance Department makes a determination that they could have, or could rescind the coverage.

Through you.

DEPUTY SPEAKER MCCLUSKEY:

Representative Fontana.

REP. FONTANA: (87th)

Through you, that's existing law. Through you.

DEPUTY SPEAKER MCCLUSKEY:

Representative Miner.

REP. MINER: (66th)

Thank you. And so the purpose of the Amendment then is to require that rescission only after the Insurance Commissioner has determined that it's appropriate?

Through you.

DEPUTY SPEAKER MCCLUSKEY:

Representative Fontana.

REP. FONTANA: (87th)

Through you, Mr. Speaker, the purpose of the Amendment is not to change the process so much as to require that the process be applied when an insurance company would seek to rescind the policy. Through you.

DEPUTY SPEAKER MCCLUSKEY:

Representative Miner.

REP. MINER: (66th)

Thank you, Mr. Speaker. I thought I understood the gentleman in the beginning to say that the reason for this was that insurance companies were rescinding insurance in the front end without the authorization of the Commissioner, and that the purpose of this Amendment was to require the Commissioner granting the authority to rescind the coverage. But I guess that's not the case.

In this case, they can rescind the coverage, but it's after the Insurance Commissioner tells them it's okay to rescind it. Through you.

DEPUTY SPEAKER MCCLUSKEY:

Representative Fontana.

REP. FONTANA: (87th)

Through you, Mr. Speaker, and I apologize if my preparatory comments were inexact.

The gentleman is correct. The goal is to, the Commissioner already has the authority to oversee the rescission of these policies for a couple of reasons that is not occurring currently. He's not getting a chance to renew them. This would require him to be able to review them prior to a movement to rescind. Through you.

So the gentleman I believe is correct in his final comments in his question to me just now.

DEPUTY SPEAKER MCCLUSKEY:

Representative Miner.

REP. MINER: (66th)

Thank you, Mr. Speaker. And so in terms of the process, in all cases the Insurance Commissioner's approval would be required upon passage of this before the insurance company could rescind coverage, while that doesn't currently exist.

It only exists currently under those in which the Insurance Commissioner decides that they can't remove coverage. Through you.

DEPUTY SPEAKER MCCLUSKEY:

Representative Fontana.

REP. FONTANA: (87th)

Through you, Mr. Speaker, I believe the gentleman and I agree, but let me just restate if I could.

The purpose of this underlying bill, and then the Amendment, which is intended to clarify the underlying bill, is to require companies that would seek to rescind these policies to come to the Commissioner for approval.

Through you.

DEPUTY SPEAKER MCCLUSKEY:

Representative Miner.

REP. MINER: (66th)

Thank you. And on the fiscal note, just to deal with the expense of this, does the gentleman know approximately how many of these instances occur annually?

Through you, Mr. Speaker.

DEPUTY SPEAKER MCCLUSKEY:

Representative Fontana.

REP. FONTANA: (87th)

Through you, Mr. Speaker, as I indicated in my initial remarks, there are roughly 50 or so

applications each year, or policies, which companies would seek to rescind.

Through you.

DEPUTY SPEAKER MCCLUSKEY:

Representative Miner.

REP. MINER: (66th)

Thank you, Mr. Speaker, and I thank the gentleman for his answers.

DEPUTY SPEAKER MCCLUSKEY:

Thank you, Sir. Would anyone else care to remark on House Amendment Schedule "A"? Will you remark further on Schedule Amendment "A"?

If not, let me try your minds. All those in favor please signify by saying Aye.

REPRESENTATIVES:

AYE.

DEPUTY SPEAKER MCCLUSKEY:

All those opposed, Nay. The Ayes have it. The Amendment is adopted.

Would you care to remark further on the bill as amended? Will you remark further on the bill as amended?

If not, will staff and guests please come to the Well of the House. Will the Members take your seats. The machine will be opened.

CLERK:

The House of Representatives is voting by Roll Call. Members to the Chamber.

The House is voting by Roll Call. Members to the Chamber.

DEPUTY SPEAKER MCCLUSKEY:

Have all the Members voted? Have all the Members voted? Will the Members please check the board to determine if your vote is properly cast.

If all the Members have voted, the machine will be locked and the Clerk will take a tally.

Will the Clerk please announce that tally.

CLERK:

House Bill Number 6531 as amended by House "A".

Total Number Voting	148
Necessary for Passage	75
Those voting Yea	112
Those voting Nay	36
Those absent and not voting	3

DEPUTY SPEAKER MCCLUSKEY:

The bill as amended is passed.

JOINT
STANDING
COMMITTEE
HEARINGS

INSURANCE AND
REAL ESTATE
PART 6
1612 - 1937

2009

have, that physician may not be an expert, you have to go somewhere else.

REP. FONTANA: Well, and as I said on a couple of occasions, if all we cared about was cost, we'd all be driving Yugos. The fact is we look at other things besides costs.

MATTHEW KATZ: Completely agree.

REP. FONTANA: Questions for Matt from members of the committee?

There are no more Yugos anymore. That's true.

MATTHEW KATZ: Maybe Connecticut can start making them. It may help us out.

REP. FONTANA: All right. Thank you, Matt.

MATTHEW KATZ: Thank you very much.

REP. FONTANA: Looking for to your help with that.

MATTHEW KATZ: Thank you.

REP. FONTANA: Anyone else to testify on Senate Bill 959? Seeing none, we'll proceed to House Bill 6531.

And is Lynn Gelinas? Lynn Gelinas will be followed by Sue Giacalone.

LYNN GELINAS: Good afternoon, members of the insurance committee. My name is Lynn Gelinas, and I'm here to testify in support of House Bill 6531, An Act Clarifying Post Claims Underwriting.

In May 2007 I decided to change my job. Since my husband was self-employed, I always carried

the medical insurance for my family through my employer. The new insurance would be effective August 1, '07, so I just needed to get inexpensive short-term policy to cover myself, my husband and my two children.

I went online and looked at different plans through Anthem and HealthNet. The cost for the four of us was about a thousand a month, so I had to find something else.

On June 5, '07, I called HPA, Health Plan Administrators, and requested a quote. I answered "no" to eight questions over the phone and told him the medications we all take.

Seven of the eight questions were short and straightforward questions, but Question No. 6 was not. It stated, an 88-word question, "Within the past five years have you or any person proposed for coverage been aware of, received an abnormal test report, been diagnosed with, treated by or received follow-up care with a member of the medical profession or taken medication for heart disorder including but not limited to heart attack, stroke, cancer, tumor, emphysema or COPD, diabetes, liver disorder, kidney disorder other than stones, degenerative disk disease or herniated disc, rheumatoid arthritis or psoriatic arthritis, degenerative joint disease of the knees or hips, alcohol abuse or chemical dependency, hemophilia?"

I was told to answer the question regarding myself and/or anyone else on the policy. I then was quoted 136 a month with a $2,500 deductible. I told the representative from Health Plan Administrators I wanted to check out his company and I'd call him back. I then

Googled them and saw that they were registered with the State of Connecticut

Two days later I called the that same representative back to say I checked them out and wanted to purchase a policy. He said my information was no longer in the computer and he'd have to -- I'd have to reapply.

He asked the same eight questions as mentioned before, including the that 88-word one. He quoted me a premium $269 a month, $133 more than two days ago. I was angry that the premium went up so much, and he told me the computer calculates the quote and he didn't know why it was different. Thinking I was scammed, I hung up the phone.

Thinking about it later in that day, I realized I needed health insurance, so I called back and got another agent, Christine. She asked those same eight questions, and I also told her the medications we all take.

I was then quoted $263 a month with a $2,500 deductible. And then she said there would be a $100 application fee. Coverage would begin June 8, '07. She did not ask to speak to my husband.

I downloaded my temporary insurance card. She never asked me to sign anything. I never even saw the completed application or had a chance to review it for accuracy of Christine's entries on the application until later on.

Then my husband went into the hospital July 28, '07 with congestive heart failure. Health Plan Administrators was notified, and I assumed he would be covered. Steve died 11 days later from surgery for a valve

replacement.

On October 16, '07, I received a certified letter from Caroline Wallin, analyst with HPA, stating there was a discrepancy with the way I answered Question No. 6. She requested a written response within ten days. She said the question was answered "no," which contradicts the information they received from my husband's primary care physician, Dr. Deluca.

Dr. Deluca stated that my husband was seen in 2003, 2004 and 2006 for tests on his heart. They also enclosed the application that I'd never even seen before, but the eight questions were familiar to me.

As I said before, I never signed the application since these questions were asked over the phone, but my name and my husband's were typed on the signature lines. After reading her letter, I began to cry. I had lost my husband just two months ago and now they are questioning the application which I thought might mean they would deny all my claims.

I typed a letter in response and faxed it to Ms. Wallin. I stated how surprised I was to receive her letter and stated I was not aware that my husband had a heart problem. All I knew of his heart problems was that he had a heart murmur. He never disclosed to me that he was diagnosed in 2003 with mild aortic stenosis, as Dr. Deluca's records indicated.

Five months later I received several letters from HPA saying all the doctors, the labs and hospital for Steve's claims were denied for treatment of preexisting condition that was

not disclosed on the application.

All the letters from HPA said I can appeal the denial in writing within 60 days after receipt of the notice, which I did, but they're still not paid. The bills total about $200,000.

I contacted the Office of Healthcare Advocate for assistance with this case. They have contacted HPA and explained the situation and requested that HPA allow me the opportunity to explain the circumstances of the application, my lack of knowledge of the preexisting condition, but HPA would not budge.

Today, a year and a half later, the bills still aren't paid. In September I began paying $5 or $10 a month to the doctors and the labs. And Waterbury Hospital is still fighting HPA because it believes they were wrong. Thank you.

REP. FONTANA: Lynn, thank you, first, very much for coming to testifying and taking time out of your day, so -- anything else to say?

I'm very sorry for your loss. I find this situation extremely distressful, and unfortunately, it's believe it's (inaudible), and I think that there are companies out there -- and, as you say, we have companies like Anthem and the larger companies in the state who provide a good product in the main and then they charge accordingly, and unfortunately your situation looks a little bit little bit less costly, and you went to a company which maybe is more interested in taking your money and then trying to get out from underneath the claim.

LYNN GELINAS: [Inaudible] the writing was done

(inaudible).

REP. FONTANA: And as you say in your testimony, you did everything you were asked to do. You called them with the number. You spoke to them over the phone. You didn't refuse to take a copy of the application. They sent you the cards.

And to the extent that you had to answer Question 6 times, I mean, it's -- I mean in my life I don't know if you asked me the same questions -- the same question three times over the span of several days would I give you the exact same answer, particularly to an 88-word question, as you say, that you have to keep in mind all those situations.

I find this very disconcerting, very disconcerting, and I think we need to do something about this, so I thank you very for your time. I look forward to working with you and others, including an advocate, to try to get this fixed.

SUSAN GIACALONE: Are there questions members of the committee for -- thank you for coming.

LYNN GELINAS: You're welcome.

REP. FONTANA: Sue Giacalone followed by Brian Quigley.

SUSAN GIACALONE: good afternoon, Senator Crisco, Representative Fontana, members of the Insurance and Real Estate Committee. For the record, my name Susan Giacalone, and I'm here on behalf of the Insurance Association of Connecticut. I have submitted written testimony, so I'll try to keep my comments brief.

HB6531

We are only here testifying on one section of the bill which is subsection (h) which would require the insurance department, along with the office of the healthcare advocate and the attorney general's office to develop uniform and readable applications for each line of insurance authorized to be sold within the state.

That's very problematic for -- especially for life companies and P&C companies in that you have the office of healthcare advocate dictating an application -- the applications insurers use are -- allow them to individualize the product. It keeps them competitive, developing new products to have a standardized form and removing that ability to make innovative and new products.

Also, you have people who have -- I would argue, little knowledge of the P&C and life industry making determinations on what should be in the application

What does the Office of Healthcare Advocate know about errors and omissions policies or comments of what to know -- to ask? You would have to change our computer systems (inaudible) Connecticut to comply with the department (inaudible). Thank you.

REP. FONTANA: Thank you, Sue. I'm pretty clear on what you said.

Questions for Sue from members of the committee? Seeing none, thank you, Sue. Brian Quigley, please.

HB6531

BRIAN QUIGLEY: Thank you again, Chairman Fontana, members of the committee. Brian Quigley for

CAHP, testifying in opposition to House Bill 6531 concerning postclaims underwriting.

Our concern is that the law has been in place for a while now and certainly our member plans tell me that it's working and that the Insurance Department is very aggressive in pursuing these issues when they're recorded, so we're not sure why the bill needs to be changed at this point.

One of the things allowed under the current law is that if a plan identifies that it has done complete medical underwriting, that it can make a rescission and if they have to (inaudible) back, that's challenged by the consumer, and that would go to the department.

The fact situation described by the earlier witness, it seems to me, would be covered under the current law about any need for amendment in the law, and I believe that's the understanding of the Insurance Department, so I don't know if that happened before the law was passed or why it hasn't been reported to the Insurance Department. But my understanding is the current law would cover that.

The process in this bill seems especially cumbersome in comparison to the current law. You have to file to say you've done your underwriting. The department gets back to you, and then you have to file for approval of a rescission. It seems to me that the current thought process is simple and effective. There's regulations on it, so we would question the need for that.

On the issue of uniform applications, we're very concerned about all applications being

determined as described in the bill. Applications are tailored to specific products. Many of them are used nationally without variation. If there are specific provisions that the legislature/the department feels need to be uniform because of abuses or concerns about understandability, we would understand that.

But to say that all carriers have to use the same application when their products may differ, their underwriting requirements may differ, some may want more information, some want less, so from a practical standpoint, it's very hard to understand how the department in conjunction with the attorney general and the advocate would be determining uniform applications across policy lines, across companies.

So we would be very concerned about the usefulness of those applications and the costs of compliance by carriers who are trying to reduce costs by having applications uniform across states, et cetera.

So we think this bill is not necessary and will add to costs and complexity in the system where it's not necessary.
Be happy to answer any questions.

REP. FONTANA: Thank you, Brian. Certainly we don't know whether the law two years ago went into effect July 1 or October 1, which could be relevant to whether or not this case was brought to the process you mentioned.

And certainly you raise the same point that Sue did about the applicability of uniform applications. It seems to me perhaps we should be limiting it at this point just to

individual health, because individual health seems to be the situation where we seem to experience these problems from time to time.

BRIAN QUIGLEY: Again, even on individual health, to the extent company's benefits different to the extent that underwriting requirements differ, if there are uniform provisions in an application that (inaudible) necessary. And we've seen this in other states, where a portion of the application is uniform. But to the extent carriers have different information that they want that's not answered in those questions, that they would be able to customize those applications.

And the way this bill reads, you wouldn't be able to customized beyond what was uniform, even on an individual health policy.

You know, for instance, if somebody had wellness benefit on an individual policy, they'd want to ask questions about that. Whereas if somebody doesn't have a wellness benefit, you wouldn't have the need to answer those questions.

So how do you make that uniform in advance by the Insurance Department, the Attorney General and the health advocate?
So we would like to --

REP. FONTANA: Well, I suppose they could -- it could file with the commissioner. I think it have -- put the use in file or whatever -- I mean, it could file it. If he didn't like it, he could just say no, you're not going to. do that.

BRIAN QUIGLEY: That's the current process. As I read this bill, the applications would be

determined in advance and companies would have to use them. Maybe the wording of it that is most problematic, because I don't read it that way. That once the applications are established, and assuming it's a process with three regulators having to reach agreement on what the application will be, it's awfully cumbersome for a carrier to then say, all right, here's our application. Does it have to go through that whole review process again? We think the current process where the insurance commissioner has the ability -- has the requirement to review those applications, because they are a part of the contract, makes the most sense, without imposing additional requirements.

Again, if there's a need to look at what provisions should be uniform, that's a different question than saying you have to have uniform applications, which as I read this bill would be established in advance, respective of companies' benefit plans or underwriting (inaudible).

REP. FONTANA: I think there's a problem, Brian. So we're hopeful we can have your help in getting it resolved.

BRIAN QUIGLEY: Right. And to the extent there are problems, I think they're fixable in the application and the disclosure process without having to go through what we view as a very cumbersome. process.

REP. FONTANA: Thank you: Questions for Brian from members of the committee? Thank you, Brian.

That concludes testimony on 6531, unless there's someone else here who would like to testify on that bill.

REP. FONTANA: Thanks, Commissioner.

THOMAS SULLIVAN: Thank you.

REP. FONTANA: Next up on House Bill 6531 will be Kevin Lembo and the Attorney General, if he's here.

Welcome.

KEVIN LEMBO: Good afternoon, Representative Fontana, Senator Crisco, Representative D'Amelio, members of the committee, I'm Kevin Lembo. I'm a state healthcare advocate, and I thank you for this opportunity to be before you today.

I should begin by saying the Attorney General just sent word that a decision has come down from the Supreme Court that has kept him in a different branch of government today. So he sends his apologies, and I will try to wing it, as it were, on the utilization review portion that he was going to cover in our testimony.

I appreciate the opportunity to testify in support of House Bill 6531, An Act Clarifying Postclaims Underwriting. This legislation clarified the intent of legislation passed last year, jointly supported by my office, the Office of the Attorney General, and the Insurance Department.

Specifically this new House Bill would require the insurance commissioner's approval of any rescission, cancellation or limitation of an insurance policy after the insured files a claim.

In 2007, the general assembly approved a law

designed to prevent these abuses. Unfortunately, the law's effectiveness and efficacy in protecting insureds has been undermined by an interpretation that the Insurance Department has made of that law.

House Bill 6531 seeks to clarify the original intent of the law and restore the true protections for the insured. Under the department's interpretation of Public Act 07-113, as long as an insurer in its own judgment under limited guidance has completed medical underwriting, then the insured can skip over the prior approval process and rescind a policy.

This undermines the original ledge lay of it intent for several reasons. Short-term policies are not medically underwritten. And as a rule, medical underwriting involves much more than the process used in the short-term market, which is often a five- to ten-question form.

The Insurance Department has substituted a filled-out form for short-term insurance (inaudible) medical underwriting. And no company has admitted that it hasn't completed medical underwriting under the new criteria. The purpose of Public Act 07-113 was to shift the burden of proof from consumers to the insurer. Rescission is a drastic remedy and should only be applied when the insurer can prove to a third party that the process was legitimate. Searching shears of medical records from multiple providers to find the slimmest possible and potentially unsupportable evidence of a preexisting condition based on a five-question broadly worded application and then rescinding the policy with no opportunity for the enrollee to

challenge that process is certainly abuse of that consumer.

This new bill would revise the current law to clarify medical underwriting involves considerations beyond filling out a simple form; that short-term policies of six months or less are not medically underwritten. Therefore, their rescission requires Insurance Department's approval.

The burden is on every insurer to go through a prior approval process in every case to prove knowing misstatements or omissions in applications prior to rescission, cancellation or limitation.

No insurer is allowed to undertake an investigation for records from providers beyond those directly related to the alleged postclaim or preexisting condition.

Brokers will be held responsible for their conduct in assisting consumers with applications, and uniform and less-confusing applications should be used that define things like "sign" or "symptom."

As more and more people are unemployed and take lower paying jobs without access to employer-sponsored coverage, they will turn to the individual market more and more. The legislature needs to provide this growing number of people with those additional benefits that I believe you thought you did last year.

I urge the committee's favorable action on House Bill 6531, and I'm happy to take your questions.

REP. FONTANA: Thank you, Kevin. And let me start by asking, are you seeing a large or growing number of complaints to your office on this subject.

KEVIN LEMBO: A pretty consistent number, Representative Fontana, but it's becoming more difficult, because I think now that the new law is in place and the regulation interprets medical underwriting in the company's own view as being the standard to get around the law, we're having a much more difficult time getting the companies to re-review those rescissions and open them up and take a second look.

In fact, I think they're (inaudible).

REP. FONTANA: As an I said, we had testimony from Lynn Gelinas earlier, and there was a question as to whether or not she was able to avail herself of your office's help because her case occurred in the summer, summer of 2007 and that law, as you indicated, was passed in 2007.

KEVIN LEMBO: Right.

REP. FONTANA: Did her case occur prior to the effective date of that act?

KEVIN LEMBO: I believe it did, and we did take a run at bringing it back to the company but were unsuccessful, as she laid out for you.

REP. FONTANA: Thank you. Are there questions for Kevin Lembo? Senator Crisco. Oh, Representative Schofield?

Representative Altobello?

REP. ALTOBELLO: Thank you, Mr. Chairman.

Good afternoon, have you had an opportunity to read the Insurance Department's testimony on this?

KEVIN LEMBO: I have not, Representative Altobello.

REP. ALTOBELLO: Did you -- okay. And I don't believe they read it into the record.

They offer a different take on this bill. (inaudible) say it that way.

KEVIN LEMBO: And if I may, Representative Altobello, there certainly will be differences of opinion on what's appropriate and what's not.

We are committed to working with you and to continue to work with the department. I think this bill offers us an opportunity to reopen that dialogue. (inaudible) it has been closed up until now.

REP. ALTOBELLO: Thank you. And I believe Chairman Fontana asked you about how many cases came up before you, and you didn't really respond in a --

KEVIN LEMBO: Yes.

REP. ALTOBELLO: -- specific way.

KEVIN LEMBO: I think he asked if the numbers had increased. They've been pretty steady. They tend to be in the teens to low 20s in any given year. It's not a large number.

REP. ALTOBELLO: Thank you.

KEVIN LEMBO: But that is obviously a devastating occurrence for those 20 families.

REP. ALTOBELLO: Thank you, Mr. Chairman.

KEVIN LEMBO: Thank you.

REP. FONTANA: You're welcome.

And, Kevin, let me just ask you to -- as I've indicated, I think this is something we really need to get straight. It's something that mattered a great deal to me when we tried to do it two years ago, and it grieves me that we haven't perhaps nailed down exactly how this thing is supposed to work.

Let me just ask you, though, on the issue of the uniform applications, you know, Brian Quigley raised the point of, well, what if they have an additional thing that they want to raise?

So is there a manner in which we could create a uniform application with the commissioner for universal health policies and then an expedited process by which insurers who wanted to ask nonstandard questions could get his approval for the wording, for -- well, to ask those questions in the first place and then the wording of those questions.
Would that be doable?

KEVIN LEMBO: I think it certainly would be. There are a handful -- more than a handful these days of companies that participate in the individual market in Connecticut, it's the exception rather than the rule, that I think we should quickly raise the issue of wellness

programs and the like, that those come into play in the questions.

When I requested (inaudible) national about this in an NAIC meeting, their concerns were really mostly about the individual mandates in a specific state. So in a state that has a good mental health mandate, they didn't ask more questions about mental health because they don't want to get under that pile with claims.

So I think the answer to your question is absolutely yes. If we can at the end of the day reach a consensus on the stock questions and an expedited process, and if we can ensure readability and understandability and know that they pass a standard, then I think we'll be far better off than we are right now, if it includes, again, that glossary of what these terms actually mean.

REP. FONTANA: Yes, I was just thinking about that 88-word question Ms. Gelinas was talking about on the application. And I have to admit, just reading it, it's hard for me to see how you can get through that without possibly running afoul of something, because it asks you so many multipart questions.

I'm thinking about when I donate blood, it's simply yes, no? Have you ever been to England before 1982. Have you ever, you know -- it's a yes-no, yes-no on each individual item. It's not some global can you tell us anything that might ever be of a concern to us if you give blood. I mean, it seems like it's designed to make sure that things are done properly.

An 88-word question like that seems to me

either designed to expedite things so they can get your money and then send you the cards, or to perhaps catch you up on something and then have a global catchall they can exploit down the road.

KEVIN LEMBO: You're correct, Representative. By then it's very difficult to answer a question like that. And if you feel the need to -- you've (inaudible) binary question, so even -- they're yes-no in an 88-word question, and it's important to point out as an aside, that one of the rebuttals to the bill is that, well, these are already filed with the department for approval.

I would say to you the reason we need the bill is that these are already approved by the department, so that 88-word question is already approved and clearly problematic for consumers. And then you put that alongside two boxes that say yes and no and no other opportunity to comment, note, further feedback on the -- it -- it sort of asks for trouble.

REP. FONTANA: Well, especially since in this particular case the question was being asked verbally, which I think most people are have trouble following 88 words straight when they're having to pay attention to the last word and keep in mind the first word.

I know I actually had temporary insurance for a three- or four-month period back in 1996, and it was a written application, so at least I could see it, think about it and I could put down my answers. I didn't have somebody else putting it down for me, much less having to remember an 88-word question.

KEVIN LEMBO: And if I may, there's concern as well

that when a third party, whether it be a broker or someone else on a toll-free number is assisting you, sometimes those questions also get short-cud because they don't want to read an 88-word question to you either. You know, has anything changed since last application?

We had a case where a long question was asked and was short-cut by the broker to "has anything changed since the last application.

REP. FONTANA: Again, putting the burden --

KEVIN LEMBO: With the best of intentions.

REP. FONTANA: Right, but the burden -- the burden is always on the applicant here.

KEVIN LEMBO: Right.

REP. FONTANA: And it -- the resources are all with the insurance company, and --

KEVIN LEMBO: We can probably strike a balance.

REP. FONTANA: Yes. I hope we can sit down perhaps with the Commissioner and try to come up with something that works here. Good. Thank you.

Other questions for Kevin Lembo, members of committee? Thank you very much.

KEVIN LEMBO: If I may, just one more?

REP. FONTANA: Sure.

KEVIN LEMBO: Thanks.

I'm also here to support and thank the committee for raising Senate Bill 958, An Act

Quality is Our Bottom Line

Insurance & Real Estate Committee
Public Hearing

Tuesday, February 24, 2009

Connecticut Association of Health Plans

Testimony regarding

HB 6531 AA Clarifying Postclaims Underwriting.

The Connecticut Association of Health Plans respectfully urges the Committee's rejection of HB 6531 AA Clarifying Postclaims Underwriting.

In 2007, the legislature acted to protect consumers against inappropriate rescissions with the adoption of PA **PA 07-113 AN ACT CONCERNING POSTCLAIMS UNDERWRITING.**

That act prohibits health insurers from rescinding, canceling, or limiting coverage based on information a person submitted with or omitted from an insurance application if, before issuing the policy, the insurer or HMO did not perform a thorough medical underwriting process. This includes resolving all reasonable medical questions based on the written application.

However, the act allows a rescission, cancellation, or limitation based on the application when the insurance commissioner approves it. It permits the commissioner to approve the action if the enrollee, or the enrollee's representative, knew or should have known that information material to the insurer's or HMO's risk assumption was (1) false when included with the application or (2) omitted from the application. Regardless, it prohibits an insurer or HMO from rescinding, canceling, or limiting any coverage that has been effective for more than two years.

We would submit that PA 07-113 strikes the right balance between assuring that the consumer is rightly protected and that the insurer has the right to act upon the knowledge that information was falsely represented.

HB 6531 significantly alters the agreement reached two years ago and if passed will likely result in significant disruption in the individual market as well as increased costs.

We urge your rejection. Thank you for your consideration.

280 Trumbull Street | 25th Floor | Hartford, CT 06103-3597 | 860 275 8372 | Fax 860 541 4923 www.ctahp.org

Christine A. Cappiello
Director
Government Relations

Anthem Blue Cross and Blue Shield
370 Bassett Road
North Haven, CT 06473
Tel 203 985-6360
Fax 203 234-5157
christine cappiello@anthem com

Anthem.

February 24, 2009

Statement
Of
Anthem Blue Cross and Blue Shield
On
HB 6531 An Act Clarifying Postclaims Underwriting

Good afternoon Senator Crisco, Representative Fontana and members of the Insurance and Real Estate Committee, my name is Christine Cappiello and I am the Director of Government Relations for Anthem Blue Cross and Blue Shield in CT. I am here to testify against **HB 6531 An Act Clarifying Postclaims Underwriting.**

Anthem is opposed to this legislation because we believe it is unnecessary. In 2007, this committee and the Legislature passed **07-113 AN ACT CONCERNING POSTCLAIMS UNDERWRITING**, which was landmark legislation passed to address a situation that arose in the individual insurance market. It set clear perimeters around when insurers can rescind individual applications and apply pre-existing conditions. This legislation by all accounts seems to be obtaining its goal of stopping the practices of carriers rescinding applications without have a basis to do so. If this bill were to go forward it would essentially halt the individual application process as we know it because adding involvement of any party in the enrollment process would mean delays cause significant customer abrasion.

Our concerns also lie around these things: 1) what are the credentials of the people involved, 2) is there a potential violation of confidentiality for our members if we were to disclose information about specific conditions to the DOI, 3) what is the impact to our established timeframes for resolving claims, and 4) what is the added administrative burden of adding another layer to the process and cost.

Members are sufficiently protected by the existing law and Insurance Department bulletin, both from two years ago, which clearly establish the expectation that thorough medical underwriting

In Connecticut: Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans, Inc.
In Maine: Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Maine, Inc.
In New Hampshire: Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of New Hampshire
Independent licensees of the Blue Cross and Blue Shield Association.
®Registered marks Blue Cross and Blue Shield Association.

should be conducted at the point of application if an insurer intends to cancel, limit, or rescind coverage based on application responses. Under the existing law and bulletin, Insurance Department approval is required if a carrier did not perform complete medical underwriting at the point of application. That type of approach strikes the proper balance for these issues, especially knowing that there are appeal and complaint avenues as well.

We strongly urge the committee to reject this legislation.

UnitedHealth Group

Good afternoon Chairman Crisco and Chairman Fontana and members of the Insurance and Real Estate committee. UnitedHealth Group offers products to individuals and families in over 40 states. In Connecticut, we offer individual coverage through Golden Rule Insurance. We currently cover over 20,000 Connecticut residents through individual major medical and short-term major medical coverage. Golden Rule has been offering health insurance products for more than 60 years. In Ct we are one of the largest carriers of long-term and short-term policies. HB 6531 will increase the premiums of short-term polices at a time when CT residents are losing their jobs and needing short-term health coverage and need it to be affordable. **We oppose HB 6531 AN ACT CLARIFYING POSTCLAIMS UNDERWRITING.**

This bill is amending a law that was a national model in 2006 when it was passed and the insurance industry, including ourselves, worked with the Office of HealthCare Advocate, Department of Insurance, Attorney General and the General Assembly on crafting this legislation. The Healthcare Advocate even testified in Washington D.C about the post-claims underwriting bill being a national model.

We also have questions about certain parts of the bill. The definition of "completion of medical underwriting" has a portion that reads..."and all reasonable questions related to written information submitted on or with or information omitted from an insurance application have been resolved..." How is a carrier supposed to know how to resolve all questions on omitted information?

The definition of Limitation" means a restriction or refusal of coverage." Does this mean that we have to get the Commissioner's approval on all policies that we would place a rider on? This will significantly slow down the process of issuing business and getting policies out the door to CT residents at a time when there is a great need for short-term insurance policies for no more than six months to laid off and unemployed residents. Additionally, all of the back and forth notices between the DOI, the insurer, the applicant and back to the DOI again is too administratively expensive and time consuming– adding to the cost of premiums for those small numbers that actually get issued a policy- even when they agree to the rider limitation.

If we are not allowed to rescind two years after issue is fiscally irresponsible- fraud is an issue at any time and this type of requirement will also add an increase to premiums.

We thank you for your consideration of our concerns. We look forward to working with the committee on this issue.

Jason C. Martiesian
Vice President, State Government Affairs
UnitedHealth Group
475 Kilvert Street
Warwick, Rhode Island 02886
Phone: 401.732.7283
Fax: 401.732.7536

STATEMENT

INSURANCE ASSOCIATION OF CONNECTICUT

Insurance and Real Estate Committee

February 24, 2009

HB 6531, An Act Clarifying Postclaims Underwriting

The Insurance Association of Connecticut is opposed to subsection (h) of Section 2 of HB 6531, An Act Clarifying Postclaims Underwriting, as it is overly broad and will unnecessary alter the landscape for insurance in Connecticut.

Subsection (h) of Section 2 of HB 6531 would require the Insurance Commissioner to develop, in conjunction with the Office of the Health Care Advocate and the Attorney General, uniform and readable applications for each line of insurance authorized to be sold in this state. Every insurer licensed to do business in this state will be required to use the application. This requirement would bring the industry to a standstill. Insurers would not be able to develop new and innovative products to meet emerging consumer needs. Insurers would have to wait for the Commissioner to develop a new application for any new product.

Individualized applications permit insurers to be innovative and develop products to meet consumer need. Such products need specialized information, obtained from the application, which permits insurers to properly underwrite the risk. Insurers have spent significant amounts of time crafting the questions that they use on their applications. A standardized application would not ask for all the information that was needed in order to administer coverage nor would

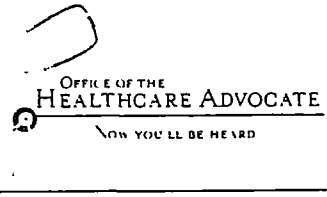
insurers be able to comply with the organizational and underwriting rules governing the industry. Insurers don't want to collect any information that they don't need because it presents privacy/security risks. For example, an insurer's system may never capture unneeded information contained on the standardized application, however, the insurer will be charged with protection and knowledge of such information if ever a problem arose. Insurers would have to develop new computer systems and data collections and underwriting processes just for Connecticut for no demonstrated reason. This is fundamentally unfair for the both the insured and insurer.

Individualized applications lead to unique products that equate to a competitive market. A single application used by all insurers would impair creativity in the market, curtailing the competitive nature of Connecticut's vibrant life and property and casualty markets. The impediment to developing new products for consumers; increased administrative costs, and the lack of a competitive market that would result from standardized applications only serve to increase the costs of insurance in Connecticut.

Furthermore, life insurers and property and casualty insurers would be dependent on individuals with limited knowledge of their lines of insurance to develop applications, yet insurers would be held responsible for their actions. What benefit does the Office of the Health Care Advocate add to developing an application for a homeowner's policy or an Errors and Omissions Policy? What knowledge does the Attorney General have regarding the impact that information, requested on an insurance application, has on the underwriting and actuarial process? Currently, insurers are held to a strict standard in any dispute

that may arise out of the application process based upon the rationale that insurers develop the application. That standard will have to change, as the insurer would be charged with that strict liability without having had the benefit of writing the question, which is grossly unfair.

The IAC urges your rejection of subsection (h) of Section 2 of HB 6531.



RICHARD BLUMENTHAL		KEVIN LEMBO
ATTORNEY GENERAL		HEALTHCARE ADVOCATE
State of Connecticut		**State of Connecticut**

TESTIMONY OF
ATTORNEY GENERAL RICHARD BLUMENTHAL AND
HEALTHCARE ADVOCATE KEVIN LEMBO
BEFORE THE INSURANCE AND REAL ESTATE COMMITTEE
FEBRUARY 24, 2009

We appreciate the opportunity to support House Bill 6531, *An Act Clarifying Postclaims Underwriting*.

This legislation clarifies the intent of legislation, jointly supported by our offices and the Insurance Department, to provide fairness and equity for individuals who are insured through individual health insurance. Specifically, House Bill 6531 requires the Insurance Commissioner's approval on any rescission, cancellation or limitation of an individual health insurance policy after the insured files a claim. The Insurance Commissioner must review the proposed action by the insurer and grant approval only if the Commissioner determines that the insured was fairly apprised of the specific information sought in the application for insurance and failed to provide full disclosure. In addition, if the reason for the insurer's proposed action is based on a preexisting medical condition, the Commissioner may approve such action only if the preexisting medical condition has a direct relationship to the insurance claim and the insurer has not violated statutory limits on how far back it may look to review such preexisting condition.

Over the years, our offices have received complaints from patients who have paid thousands of dollars in health insurance premiums only to have the insurer decline coverage for serious illnesses such as cancer. The insurer may cite a supposedly false statement on the application signed by the individual. In one example, the patient was tested prior to filing an insurance application for kidney disease and received a clean bill of health as a result of a negative and dispositive test result. Three months after enrollment the patient was hospitalized on an emergency basis and her insurance company retroactively terminated her policy, citing as its basis for doing so a statement she made to a question on the application which asked whether she had received consultation for kidney disease. The patient, who reasonably believed she had no kidney disease, answered "no." The health insurer's termination of her policy forced her to pay tens of thousands of dollars out of pocket for an unforeseen condition that she had every reason to believe would be covered. There was clearly no intent to deceive the insurer.

These retrospective reviews happen all too frequently -- well into the policy period at a time when patients have good reason to believe they are protected by the coverage they have purchased. Many have suffered severe harm.

In 2007, the General Assembly approved a law designed to prevent these abuses. Unfortunately, the law's effectiveness and efficacy in protecting insureds has been undermined by the Insurance Department's interpretations of the law. House Bill 6531 seeks to clarify the original intent of the law, restoring its true protections for insureds.

Upon the passage of the original act, P.A. 07-113, we believed that the law would reduce the number of rescissions in the short-term market, where medical underwriting does not play a factor. In fact, we and the Insurance Department agreed at the time that the short-term market had taken off and historically been a breeding ground for conduct such as rescissions and pre-existing condition limitations.

Under the Department's interpretation, as long as an insurer, in its own judgment under limited guidance, has completed "medical underwriting," then the insurer can skip the prior approval process and rescind a policy. This undermines the original legislation for several reasons: 1) short-term policies are not medically underwritten -- medical underwriting involves much more than the truncated process approved by the Insurance Department in the short-term market; 2) the Insurance Department has approved the use of a filled out form for short-term insurance as a substitute for medical underwriting; and 3) because the Insurance Department has, in effect, eliminated any meaning to medical underwriting no company has admitted that it hasn't completed medical underwriting. You heard Ms. Gelinas tell the story of her short-term policy application. That is just one example of the serious problem consumers face under the Insurance Department's interpretation of the law.

The Insurance Department sent out a very limited data call to short-term insurers this year, after Congress requested that it do so. (Abuses in the individual market are the subject of broad investigation.) The first question asks insurers for the number of times they rescinded policies for which they failed to complete underwriting, as defined by the Department. Seven companies responded. What were their answers?

Aetna Life Insurance Company	None
Connecticare Inc.	None
American Enterprise Group, Inc.	None
Anthem Health Plans, Inc.	None
Golden Rule Insurance Company	None
Celtic Insurance Company	None
Time Insurance Company	None

No surprise here. When an insurer is allowed to determine for itself, without review, whether or not it completed medical underwriting, we cannot be surprised at its response. It's very much the fox guarding the hen house.

Shortly after the Insurance Department issued its data call, the Office of the Healthcare Advocate believed that the survey sent to insurers failed to capture the real picture. So, OHA sent a follow-up survey, in an attempt to determine whether the situation improved under P.A. 07-113 and the Department's interpretation of it. Despite the failure of several companies to respond to this statutorily authorized survey on the monitoring of the implementation of new laws, the information received thus far paints a different picture than the Department's on the law's effectiveness, and this is directly traceable to the Department's interpretation. We look forward to sharing the findings once the effort is complete.

The purpose of P.A. 07-113 was to shift the burden of proof from consumers to insurers. Rescission is a drastic remedy and should only be applied where the insurer can prove to a third party that its process was legitimate. It is clearly an abusive insurance practice to search years of medical records from multiple providers to find the slimmest possible and potentially unsupportable evidence of a pre-existing condition based on a five-question broadly worded application, and rescind a policy with no opportunity for the enrollee to challenge the process. Yet that is what is occurring now.

Insurers that write short-term individual policies claim that they do not rescind enough policies to make this law necessary. They also commonly claim that they would go out of business if they had to go through a prior approval process for each rescission. One look at the Insurance Department's own numbers easily refutes those contentions. As an example, Golden Rule had 8,933policies in effect between October 1, 2007 and October 1, 2008. It rescinded 28 policies during that same period or 0.3% of the policies. Although each rescission was potentially catastrophic for the patients and families, the burden of a prior approval would have been minimal for Golden Rule and does not support the argument that requiring prior approval before rescission would force insurers out of the market.

Consumers presently do not have the right to an external appeal for rescissions. Leaving the final decision on rescission to the insurer on a high-value claim virtually guarantees that the rescission will take place. An outside review of such a life and death action is necessary to prevent continued abuse in the market.

Revising the current law clarifies that:

- medical underwriting involves considerations beyond the filling out of an application;
- short-term policies of six months or less are not medically underwritten; therefore, their rescission requires Insurance Department approval
- the burden is on insurers to go through the prior approval process in EVERY case to prove knowing misstatements or omissions in applications prior to rescission, cancellation or limitations;
- no insurer is allowed to undertake an investigation for records from providers beyond those directly related to an alleged pre-existing condition;
- brokers will be held responsible for their conduct in assisting consumers with applications; and
- uniform and less confusing applications shall be used, and clearly define the meaning of terms such as "signs" or "symptoms".

As more and more people are unemployed or taking lower paying jobs without access to employer health insurance, they will turn to individual health insurance. The legislature needs to provide this growing number of people with additional protection from unfair and arbitrary actions by certain health insurers.

We urge the committee's favorable report on House Bill 6531.

CHANGES to POSTCLAIMS UNDERWRITING LAW URGENTLY NEEDED

SUPPORT H.B. 6531, An Act Clarifying Postclaims Underwriting

In 2007, the legislature passed and the Governor signed, an Act Concerning Postclaims Underwriting (P.A. 07-113). While it was intended to redress some of the worst instances of unwarranted rescissions, cancellations or limitations of insurance policies, in practice, the Act did not go far enough. Consumers are still unnecessarily and unfairly losing their insurance and ending up with thousands of dollars in medical bills when their insurers fail to pay providers and then rescind their policies. Prescriptive legislation is required now to ensure that consumers are protected from the severe consequences of rescissions, cancellations or limitations of insurance policies.

The Problem:

Mary H. was tested prior to filing an insurance application for kidney disease and received a clean bill of health as a result of a negative and dispositive test result. Three months after enrollment the patient was hospitalized on an emergency basis and her insurance company retroactively terminated her policy, citing as its basis for doing so a statement she made to a question on the application which asked whether she had received consultation for kidney disease. The patient, who reasonably believed she had no kidney disease, answered "no." The health insurer's termination of her policy forced her to pay tens of thousands of dollars out of pocket for an unforeseen condition that she had every reason to believe would be covered.

The Remedy:

H.B. 6531. This bill will revise and simplify the Act by:

- Including a definitions section to make the Act more comprehensible and to clarify how terms are used;
- Stating that any individual policy of six months or less duration will not be considered medically underwritten and must, in each case, be subject to prior approval before it can be rescinded, cancelled or limited;
- Clarifying that **no** other policy can be rescinded, cancelled or limited for **any reason** without approval from the Insurance Commissioner unless the insurer or health center can prove first, through a submission to the Insurance Commissioner, that it completed medical underwriting and second, that it carries its burden through the prior approval process.
- Clarifying that the determination of whether medical underwriting is complete depends on multiple factors including the circumstances of the application, such as broker conduct and the taking of over-the-phone applications;

OVER⇒

- Clarifying that the insurer also has the burden, prior to rescission cancellation or limitation based on a statement on or omission from an application, of proving a knowing misstatement or omission on the application;
- Limiting the time period of investigation of a claim for a pre-existing condition to the retroactive time period for consideration of a pre-existing condition exclusion in C.G.S. § 38a-476;
- Limiting the review to the condition at issue in the claim (and clarifying statutory violations for noncompliance with this section);
- Requiring development of uniform applications for individual insurance; and
- Requiring the Insurance Commissioner to review all applications and forms for compliance with pre-existing condition limitations.

WE URGE YOUR SUPPORT OF H. B. 6531 – THE TIME IS NOW.

For more information the bill or any questions you might have, please contact:

Vicki Veltri
Office of Healthcare Advocate
860-297-3982

Richard Kehoe
Office of the Attorney General
860-808-5294

TUESDAY, FEBRUARY 24, 2009 TESTIMONY:

Good afternoon members of the Insurance Committee. My name is Lynn Gelinas and I'm here to testify in support of House Bill 6531, An Act Clarifying Postclaims Underwriting.

In May 2007 I decided to change my job. Since my husband was self-employed, I always carried the medical insurance for our family through my employer. The new insurance would not be effective until 8/1/07 so I needed an inexpensive short-term policy to cover myself, my husband and my two teenage children.

I went online and looked at different plans through Anthem and Health Net. The cost for the four of us was about $1,000 per month so I had to find something else. On 6/5/07 I called HPA – Health Plan Administrators-- and requested a quote. I answered "no" to eight questions over the phone and told him the medications we all take. Seven of the eight questions were short and straightforward questions but question number 6 was not. It stated, *"Within the past 5 years have you or any person proposed for coverage been aware of, received an abnormal test report, been diagnosed with, treated by or received follow-up care with a member of the medical profession or taken medication for heart disorder including but not limited to heat attack, stroke, cancer, tumor, emphysema or COPD, diabetes, liver disorder, kidney disorder other than stones, degenerative disc disease or herniated disc, rheumatoid or psoriatic arthritis, degenerative joint disease of the knees or hips, alcohol abuse or chemical dependency, hemophilia?"* I was told to answer the questions regarding myself and for anyone else on the policy. I was then quoted $136/month with a $2,500 deductible. I told the representative from HPA I wanted to check out his company and I'd call back. I then Googled HPA and saw they were registered with the State of Connecticut.

Two days later I called the same representative back to say I checked them out and wanted to purchase a policy. He said my information was no longer in the computer so I needed to re-apply. He asked the same eight questions as mentioned before, including the 88 words in question #6, and he quoted me a premium of $269/month - $133 more than two days ago! I was angry that the premium went up so much and he told me the computer calculates the quote and didn't know why it was different. Thinking I was being scammed, I hung up.

Thinking about it later that day, I realized I needed insurance so I called back and got another agent, Christine. She asked the same eight questions, including the 88-word question #6, and I also told her the medications we all take. I was quoted $263/month with a $2,500 deductible. She said there would also be a $100 application fee. Coverage would begin 6/8/07. She did not ask to speak to my husband. I downloaded my temporary insurance cards. She never asked me to sign anything. I never even saw the completed application or had a chance to review the accuracy of Christine's entries on the application until later on.

My husband went into the hospital 7/28/07 with Congestive Heart Failure; HPA was notified and I assumed he would be covered. Steve died 11 days later after surgery for a valve replacement.

On 10/16/07 I received a certified letter from Caroline Wallin, Analyst with HPA stating there was a discrepancy with the way I answered question six, and she requested a written response

within 10 days. She said the question was answered "no" which contradicts the information they received from my husband's Primary Care Physician, Dr. Deluca. Dr. Deluca stated that my husband was seen in 2003, 2004 and 2006 for tests on his heart. They also enclosed the application that I'd never seen before but the eight questions were familiar. As I said before, I never signed the application since these questions were asked over the phone, but my name and my husband's were typed on the Signature lines. After reading her letter, I began to cry. I had lost my husband just two months ago and now they are questioning the application, which I thought might mean they would deny all the claims. I typed a letter in response and faxed it to Ms. Wallin. I stated how surprised I was to receive her letter and stated I was not aware that my husband had a heart problem. All I knew of my husband's heart problems was that he had a heart murmur. He never disclosed to me that he was diagnosed in 2003 with mild aortic stenosis, as Dr. Deluca's records indicated.

Five months later I received several letters from HPA saying all the doctors, labs and hospital for Steve's claims were being denied for "Treatment for a preexisting condition" that was not disclosed on the application. All the letters from HPA said I could appeal the denial in writing within 60 days after receipt of the notice, which I did but they still would not pay the claims. The bills total about $200,000.

I contacted the Office of the Healthcare Advocate for assistance with this case. They contacted HPA and explained the situation and requested that HPA allow me the opportunity to explain the circumstances of the application – my lack of knowledge of the pre-existing condition, but HPA would not budge.

Today, a year and a half later, the bills still aren't paid. In September, I began paying $5 to $10 per month to the doctors and labs. Waterbury Hospital is still fighting HPA because it believes that HPA was wrong.

Thank you.

ADDENDUM TO TESTIMONY OF
HEALTHCARE ADVOCATE KEVIN LEMBO
BEFORE THE INSURANCE AND REAL ESTATE COMMITTEE
FEBRUARY 24, 2009

In Support of HB 6531, An Act Clarifying Postclaims Underwriting

In order to complete the testimony of the Office of the Healthcare Advocate, we respectfully submit this addendum to our testimony. The following documents are attached:

1. Letter from Kevin Lembo, Healthcare Advocate, to Thomas Sullivan, Insurance Commissioner, re case referral and concerns with Bulletin HC-66, dated July 3, 2008
2. Letter from Thomas Sullivan to Kevin Lembo responding to Lembo letter of July 3, 2008, dated July 14, 2008
3. Letter from Kevin Lembo to Thomas Sullivan responding to Sullivan letter of July 14, 2008, dated July 23, 2008
4. Letter from Thomas Sullivan to Kevin Lembo responding to Lembo letter of July 23, 2008, dated September 4, 2008

Please contact Vicki Veltri at 297-3982 or Victoria.veltri@ct.gov with any questions or concerns. Thank you.

P.O. Box 1543 • Hartford, CT 06144 • 1-866-HMO-4446 • Fax 860-297-3992 • www.ct.gov/oha

July 3, 2008

Thomas R. Sullivan
Commissioner
Connecticut Insurance Department
P.O. Box 816
Hartford, CT 06142-0816

RE: Attached case file and clarification of Bulletin HC-66 and its interpretation of Public Act 07-113, Conn.Gen.Stat. § 38a-477b

Dear Commissioner:

I write concerning a case received in my office of an individual policy rescission. More specifically, I write seeking clarification of the Department's interpretation of Conn.Gen.Stat. § 38a-477b through its bulletin, HC-66.

The passage of Public Act, 07-113 was a collaborative effort our offices and the Office of the Attorney General. While negotiations over the language of the Act itself were arduous and difficult at times, a very strong consensus was reached, which we supported. We are concerned, though we did not envision such a problem at the time, that a portion of bulletin HC-66 may now be inconsistent with the purpose of the legislation because it does not clearly define the "completion of medical underwriting" and the "resolution of all medical questions concerning the application". The lack of definitions of these terms has left their meaning to the discretion of insurers and may allow insurers to claim they've completed medical underwriting when rescinding, canceling or limiting a policy with no further review of that underwriting unless a complaint has been made.

A clear and high standard of medical underwriting is necessary. Insurers have to be held to a uniform and definition of medical underwriting for this Act to achieve the twin goals of encouraging up-front medical underwriting and putting the burden on insurers to ensure that they do not rescind, cancel or limit policies without substantial justification.

P.O. Box 1543 • Hartford, CT 06144 • 1-866-HMO-4446 • Fax 860-297-3992 • www.ct.gov/oha

Medical underwriting goes beyond a mere review of the insured's application. It involves a more detailed examination of the application that includes weighing the risk of particular factors and obtaining additional medical evidence. Indeed, most applications require potential insureds to give express permission to the insurer to review all of the prospective insured's medical records in advance of issuing a policy or certificate of coverage.

Many insurers follow standardized guidelines, such as those of Milliman, for individual medical underwriting. These guidelines do not go strictly by an insurance application in determining whether to issue a policy to an individual. They require more examination of an applicant's medical risk than is apparent from an application. Although not all insurance companies use the same underwriting guidelines, an insurer should know that it is expected to be held to a uniform and diligent standard in its underwriting process.

We disagree with the Department's interpretation that if medical underwriting is complete and all reasonable questions related to the application are resolved, that there is nevertheless, no need to submit evidence of pre-sale underwriting to the Department prior to any rescission, cancellation or limitation on a policy, unless there is a complaint. We believe that an insurer bears the burden of proving to the Department that it has completed medical underwriting in advance of any rescission, cancellation or limitation and even in the absence of a complaint. To reduce the number of complaints received by any one of our three offices and to assist those who may never submit a complaint of a rescission, cancellation or limitation, this implicit requirement in the statute must be made part of the process.

For instance, on page 5 of the bulletin, the Department requires, that "[I]nsurers 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."

We believe that this requirement should apply to all insurers that attempt to rescind, cancel or otherwise limit policies. There is nothing in the language of § 38a-477b that restricts the Department's determination of whether medical underwriting was completed prior to any attempt to rescind, cancel or limit a policy. As the Department recognizes in HC-66, it has a duty to determine whether medical underwriting is completed. The statute makes no distinction as to whether a complaint has to be made prior to the Department's evaluation of the pre-sale underwriting. Rather, we see this evaluation of the complete medical underwriting as a first step in this process. If an insurer passes this first step, no prior approval process is necessary for rescission, cancellation or limitation, but if the insurer fails step one, then it has to go through the

prior approval process. This is the only fair way to ensure that all insurers are held to the same standards and that all consumers are equally protected by the new law.

Lastly, the accompanying file already includes a misinterpretation by Connecticare of § 38a-477b. In this case, Connecticare failed to comply with the existing guidance requiring it to submit evidence to the Department of pre-sale underwriting when an insured has made a complaint. I invite you to review this file as it is a perfect illustration of my concern: that an insurer can claim to have followed its guidelines prior to writing the policy and then rescind the policy on its own, without review by the Department. I request that you act on this case and inform Connecticare of its duty to submit evidence of pre-sale underwriting, review that underwriting and then determine whether Connecticare must go through the prior approval process prior to rescinding the consumer's policy.

I ask that you revise HC-66 to clarify the definitions of "medical underwriting" and "reasonable questions" with respect to an individual insurance application. I also request that you revise HC-66 to require the submission of evidence of pre-sale underwriting in call cases in which an insurer wishes to rescind, cancel or limit a policy.

Sincerely,

Kevin Lembo

Kevin Lembo
Healthcare Advocate

Attachment: [redacted] case

State of Connecticut

Hartford

THOMAS R. SULLIVAN
INSURANCE COMMISSIONER

P O BOX 816
HARTFORD CT 06142-0816

July 14, 2008

Kevin Lembo
Healthcare Advocate
Office of the Healthcare Advocate
PO Box 1543
Hartford, CT 06144

RE: Clarification of Bulletin HC-66

Dear Mr. Lembo:

Thank you for your letter of July 3, 2008 regarding application of Conn. Gen. Stat. §38a-477b and the interpretation of that statute as published in Bulletin HC-66. I have carefully reviewed the concerns you list in your letter and respectfully disagree with your assessment and find no need for changes in the interpretation or positions taken in Bulletin HC-66.

Conn. Gen. Stat. §38a-477b provides in relevant part:

a) Unless approval is granted pursuant to subsection (b) of this section, no insurer or health care center may rescind, cancel or limit any policy of insurance, contract, evidence of coverage or certificate that provides coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 on the basis of written information submitted on, with or omitted from an insurance application by the insured 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. No insurer or health care center may rescind, cancel or limit any such policy, contract, evidence of coverage or certificate more than two years after the effective date of the policy, contract, evidence of coverage or certificate.

(b) An insurer or health care center shall apply for approval of such rescission, cancellation or limitation by submitting such written information to the Insurance Commissioner on an application in such form as the commissioner prescribes. Such insurer or health care center shall provide a copy of the application for such approval to the insured or the insured's representative. Not later than seven business days after receipt of the application for such approval, the insured or the insured's representative shall have an opportunity to review such application and respond and

> submit relevant information to the commissioner with respect to such application. Not later than fifteen business days after the submission of information by the insured or the insured's representative, the commissioner shall issue a written decision on such application. The commissioner may approve such 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 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. Such decision shall be mailed to the insured, the insured's representative, if any, and the insurer or health care center.

As you can see, there is nothing in this statute which gives the Insurance Commissioner ("Commissioner") the authority to mandate presale medical underwriting or uniform medical underwriting standards to be imposed upon health insurers or health care centers operating in the State of Connecticut. The law establishes my authority only in the absence of presale medical underwriting being performed or an entity's failure to resolve all reasonable medical questions related to the written information submitted on, with or omitted from the insurance application before issuing the policy. Following the maxims of statutory construction, we look to the plain language of the statute and act accordingly. "[O]ur fundamental objective is to ascertain and give effect to the apparent intent of the legislature." (Internal quotation marks omitted.) *Alvarado* v. *Black*, 248 Conn. 409, 414, 728 A.2d 500 (1999). "A cardinal rule of statutory construction is that where the words of a statute are plain and unambiguous the intent of the [drafters] in enacting the statute is to be derived from the words used. . . . Where the court is provided with a clearly written rule, it need look no further for interpretive guidance." (Internal quotation marks omitted.) In reading the plain language of the statute, if I were to order all entities to perform full presale underwriting, or to adopt specific medical underwriting standards, I would be acting beyond the scope of the power and authority granted to me by the legislature. That would be considered an abuse of my discretion, and could also be seen as my trying to usurp the policymaking authority of the legislature. In addition, by ordering specific standards to be used, particularly if I were to recommend standards sold by a particular vendor such as Milliman, Inc., I could be subjected to claims of using my office to manipulate the marketplace in favor of a single vendor, restraint of trade, or other anti-competitive allegations.

Apart from the lack of statutory authority, there are practical reasons to avoid requiring full medical underwriting of the sort you appear to be advocating. To routinely request full medical records and conduct a completely unfettered medical history investigation of every applicant, without any causal predicate, could be viewed not as risk assessing, but rather "fishing" for adverse medical history. This is ripe for abuse. In addition to the potential claims of fishing, there is a need to understand the prohibitive costs associated with that sort of excessive investigatory medical underwriting being undertaken for each and every application – whether there is a reasonable causal predicate or not. The additional cost and time delay associated with this activity could have severe marketplace implications and drive health insurers and health care centers out of the market. Rather, to require investigations for cause, based on information identified in the application, or if the

application presented no cause, then upon claim submissions which raise reasonable questions or omissions or falsity, is a more prudent balancing act which provides needed consumer protections and supports a viable competitive marketplace.

You have also alleged that the implementation approach as stated in HC-66, is lacking in validation mechanisms by the Insurance Department ("Department"). However, that statement is not accurate. Market Conduct examinations include a review of medical underwriting practices and verification if the entity is performing a reasonable presale underwriting and resolving all reasonable medical questions or if in fact they are not acting as they claim. In addition, consumer complaints for rescissions, cancellations or limitations received by Consumer Affairs are reviewed to determine if appropriate presale actions were undertaken. Finally, because this Department has seen firsthand the severe consequences that abuses of this nature can cause, Insurance Department procedures require that the Legal Division be involved in any complaint dealing with a post-sale rescission, cancellation or limitation so that the complaint can be reviewed and immediate enforcement action can be undertaken in cases of alleged violations. For instance, while [redacted] did not submit a complaint to the Insurance Department regarding ConnectiCare's rescission of her policy, we have reviewed the circumstances and it appears that ConnectiCare did complete 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. The file evidences that based upon the written information on the application, ConnectiCare conducted an investigation of the medical information which was disclosed; no information was provided in those obtained additional records, or the application itself, which would have raised any reasonable medical questions indicating the need to investigate liver, gallbladder or other conditions not disclosed. Indeed, if ConnectiCare had in fact sought full medical records at time of application based on the information provided, I believe they would have been subjecting themselves to allegations that they were fishing for adverse medical conditions/history as a means of excluding a variety of pre-existing conditions.

I believe that Bulletin HC-66 is accurate and appropriate and believe no changes are necessary.

Sincerely,

Thomas R. Sullivan
Commissioner

JOINT
STANDING
COMMITTEE
HEARINGS

INSURANCE AND
REAL ESTATE
PART 7
1938 - 2261

2009

FILE COPY

July 23, 2008

Thomas R. Sullivan
Commissioner
Connecticut Insurance Department
P.O. Box 816
Hartford, CT 06142-0816

RE: Your letter of July 14, 2008

Dear Commissioner Sullivan:

I've reviewed your response of July 14, 2008 to my letter of July 3, 2008 regarding the application of Conn.Gen.Stat. § 38a-477b, and your interpretation of that statute in Bulletin HC-66. Unfortunately, your letter does not respond to the issues raised in my letter and, instead, incorrectly suggests that I made certain statements about pre-sale underwriting. I request that you review my letter again and respond to the issues raised therein.

Pre-sale Medical Underwriting and Level of Guidance Provided to Insurers and Health Care Centers

I am aware that you lack the authority to mandate presale medical underwriting or to impose uniform medical underwriting standards upon health insurers or health care centers in Connecticut. Instead, I suggested that your staff needed some kind of uniform standard to evaluate whether adequate presale underwriting was completed in order to determine whether the prior approval process must be followed. The "standard" provided in the bulletin is no more than a very general guide to insurers.

There are many variables to presale medical underwriting that the Department's guidance does not address. Specifically: the quality and clarity of the application; the role of a broker or agent in accurately completing the application; and, whether the insurer has performed any due diligence beyond a review of the application. In individual insurance, most applications are very general and have no practical use beyond that of a screening tool. There is a duty on the insurer to do more than review an application.[1] Your implication in Bulletin HC-66 that underwriting actually can be perfected by completion of an application *or* by seeking additional medical records not only illustrates our

[1] The statute itself refers to the "completion of medical underwriting *and* the resolution of all reasonable medical questions prior to the issuance of the policy."

P.O. Box 1543 • Hartford, CT 06144 • 1-866-HMO-4446 • Fax 860-297-3992 • www.ct.gov/oha

differing opinions as to the meaning of the "completion of medical underwriting," but also is inconsistent with the statute.

Even America's Health Insurance Plans (AHIP) stated in its recent testimony before Congress that there need to be clear standards in place before rescissions can take place. In that testimony, AHIP referenced what it considered to be the duties of insurers in medical underwriting, including the use of internal written underwriting guidelines, something your Department could require the insurers to demonstrate, and the use of proper applications, something that should clearly be part of a review to determine whether there may have been both completed medical underwriting and/or an unknowing omission or misrepresentation.[2]

I remain very concerned about the Department's definition of medical underwriting, which is lacking in any specific guidance to insurers. The Department must dig deeper into the underwriting practices of insurers to determine whether adequate pre-sale underwriting was completed. It is not enough to say that the insurer has guidelines and the application looks complete. The Department needs to determine whether an insurer or health care center has met its burden and it can only do that with sound procedures for evaluating the underwriting, not by vague references to the reasonableness of the insurer's review of an application.

Preliminary review of all cases in which an insurer seeks to rescind, cancel or limit a policy

I am frustrated and frankly, struck, by your unwillingness to review ***all*** cases in which an insurer proposes to rescind, cancel or limit a policy – even when the insurer claims to have completed pre-sale underwriting. The completion of pre-sale underwriting is a factual determination that should be conducted in each and every case, not just cases in which complaints are filed with your Department. As you point out in your letter, the words of the statute are unambiguous, so we look to the words used to derive intent. *Alvardo v. Black*, 248 Conn. 409, 728 A.2d 500 (1999). The statute is unambiguous in its direction to the conduct of all insurers in all cases. The statute itself envisions such a process for each "policy" -- the plain language of the legislation does not distinguish between cases in which complaints are made to the Department and those in which no complaint is filed. It applies equally to all cases in which rescission, cancellation or limitation is sought by an insurer. Market conduct examinations will not reveal all instances of this conduct until after they've occurred. The point of the legislation was to prevent the conduct from occurring, not to fix problems retroactively when consumers have already suffered great harm.

---

[2] I've attached to two examples of what I consider to be problematic applications for individual insurance. The first contains only one catch-all question concerning medical history that is not just ambiguous, but so grammatically incorrect and confusing that I'm astonished that it was approved by the Department. The second assumes that the applicant must have earned an honorary medical degree in order to properly fill out the form. I urge you to review these applications for clarity and to insist upon a uniform and comprehensible form for all insurers and consumers, such as that being proposed in California.

If our new legislation is working properly, there will not be many cases to review; however, each of these cases represents a consumer who may be facing financial hardship or worse. It should not be a burden for the Department to review all cases of this kind. It is good public policy and completely consistent with and indeed envisioned by the legislation.

Bulletin HC-69

Lastly, I note that Bulletin HC-69 makes a helpful reference to Bulletin HC-66 in informing plans what the range of a proper investigation can be – that it must be directly related to the subject of the actual claim. This is very helpful, and might be better communicated by a revision to HC-66.

Specific ConnectiCare case referenced in my letter

We still disagree on the case provided to you for consideration. Your response was unsatisfactory -- you provide no substantive guidance as to the propriety of ConnectiCare's medical underwriting. Even after our direct request, you failed to inform ConnectiCare of its obligation, even in the absence of a complaint, to submit cases to the Department for a determination of the completeness of underwriting prior to its rescission of the policy. If you fail to inform ConnectiCare and other insurers of this requirement, you will significantly undercut the protections of the legislation by providing carte blanche to the insurers to make their own determinations as to whether they have completed medical underwriting.

Our Specific Request

Now that Public Act 07-113 has been in effect for almost ten months, I believe that our position and comments on Bulletin HC-66 at the time of its publication would have been different based on the cases we've recently seen. For this reason, and in light of the issues I've raised, I ask you to modify Bulletin HC-66 as follows:

- Remind insurers and health care centers that ***each and every case*** in which an insurer seeks to rescind, cancel or limit a policy requires a submission of the case to the Department for review to determine whether the underwriting process is complete prior to the insurer canceling, rescinding or limiting the policy, if the carrier claims to have completed medical underwriting in advance of issuing the policy.
- Clarify that a determination by the Department that underwriting was not completed for a specific policy, or a carrier's admission that underwriting was not completed, will trigger the prior approval process before a rescission, cancellation or limitation can occur.
- Include specific information beyond a mere review of the application to guide the Department and the insurers in determining whether medical underwriting has been completed, including a duty to address the ambiguity of applications and the heavy involvement of brokers in the application process.
- Revision of Bulletin HC-66 to include the information contained in Bulletin HC-69.

It is vital, if you still support the goals of our post-claims underwriting bill, that these changes be immediately incorporated into a revised Bulletin HC-66. I urge you to reconsider your earlier position.

Sincerely,

Kevin Lembo
Healthcare Advocate

Please Print in Black Ink

APPLICATION FOR SHORT TERM MEDICAL INSURANCE
GOLDEN RULE INSURANCE COMPANY – LAWRENCEVILLE, ILLINOIS 62439

THIS PLAN IS ISSUED ON AN INDIVIDUAL BASIS AND IS REGULATED AS AN INDIVIDUAL HEALTH INSURANCE PLAN.

PROPOSED INSURED [redacted] First Middle Initial Last — [redacted] Birth Date — [redacted] Age — ☐ Male ☒ Female Sex

RESIDENT ADDRESS [redacted] Street City State — [redacted] ZIP — [redacted] Telephone No.

1. Are any of your dependents to be covered under the policy/certificate? ☐ Yes ☒ No If Yes, give details below.

Dependent's First Name	Relationship to You	Date of Birth*	Dependent's First Name	Relationship to You	Date of Birth*
	Spouse	/ /			/ /
		/ /			/ /
		/ /			/ /

*If born within 30 days prior to the effective date of coverage, the person will not be covered under the policy/certificate.

2. Are you or is any family member (whether or not named in this application) an expectant mother or father? If yes, coverage cannot be issued. ☐ Yes ☒ No

3. Have you or anyone named above been declined for insurance due to health reasons? If yes, state the name of each person: ☐ Yes ☒ No
(The person(s) named will not be covered under the policy/certificate.)

4. Have you or any person named in Question 1 lived in the 50 states of the USA or the District of Columbia for less than the past 12 months? If yes, state the name of each person: ☐ ☒
(The person(s) named will not be covered under the policy/certificate.)

5. Do you or any person named in Question 1 now have hospital or medical expense insurance that will not terminate prior to the requested effective date? If yes, state the name of each person: ☐ ☒
(The person(s) named will not be covered under the policy/certificate.)

6. Within the last 5 years, have you or anyone listed on the application received medical or surgical consultation, advice, or treatment, including medication, for any of the following: liver disorders, kidney disorders, emphysema, diabetes, cancer, heart or circulatory system disorders (including high blood pressure), alcohol or drug abuse or immune system disorders, including HIV infection? ☐ ☒
If yes, state the name of each person:
(The person(s) named will not be covered under the policy/certificate.)

DEDUCTIBLE: ☐ $250 ☐ $500 ☒ $1,000 ☐ $1,500 ☐ $2,500 REQUESTED EFFECTIVE DATE: 10/30/07
(See Statement of Understanding section below.)

MONTHS OF COVERAGE: ☐ 1 MO. ☐ 2 MO. ☐ 3 MO. ☐ 4 MO. ☐ 5 MO. ☒ 6 MO.

STATEMENT OF UNDERSTANDING

I have read this application and represent that the information shown on it is true and complete to the best of my knowledge and belief. I understand that: (a) no insurance will become effective unless my application is approved and the appropriate premium is actually received by Golden Rule at its Home Office with this application; (b) no benefits will be paid for a health condition that exists prior to the date insurance takes effect; and (c) if coverage is issued, the coverage will not be a continuation of any prior coverage. Incorrect or incomplete information on this application may result in voidance of coverage and claim denial. The information provided in this application, and any supplement or amendments to it, will be made a part of any policy/certificate which may be issued. I understand that for an application sent by any electronic means, insurance, if approved, will be effective the later of: (i) the requested effective date; or (ii) the day after receipt by Golden Rule. I understand that for a mailed application, insurance, if approved, will be effective the later of: (i) the requested effective date; or (ii) the day after the postmark date affixed by the U.S. Postal Service. If mailed and not postmarked by the U.S. Postal Service or if the postmark is not legible, the effective date will be the later of: (i) the requested effective date; or (ii) the date received by Golden Rule at its Home Office. I understand that the broker is only authorized to submit the application and initial premium and may not change or waive any right or requirement.

[redacted] Proposed Insured's Signature or Parent/Legal Guardian if proposed insured is a child — X [redacted] State where you signed and read application — X [redacted] Date you signed and read application

[redacted] Licensed Agent or Broker (Please Print) — [redacted] Individual Producer #

No application will be accepted if received by Golden Rule at its Home Office or Indianapolis Office more than 15 days after the date signed.

ALTERED APPLICATIONS WILL NOT BE ACCEPTED.

Important Note: "Postmark date" means the date of the postmark as affixed by the U.S. Postal Service.

GRI-AP-108-06 2520-0906

Note: P.O. Boxes are not accepted for the Resident Address.

Oct 26 2007 01:46:51 pm

SECURE SHORT TERM MEDICAL INSURANCE APPLICATION (Connecticut)
STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

Requested Effective Date:
Date: 06/08/2007
Coverage cannot be effective prior to the termination of any other insurance coverage in force

Deductible: $2500
Plan: SECURE STM 2
6 MONTH
Coinsurance: 80/20

Payment Type	CCARD
Card Type	[redacted]
Name	[redacted]
Number	[redacted]
Expire Date	0610

APPLICANT: APP. ID. 122512 **CASE NO.** IS01051381

Name:	[redacted]	Date of Birth:	[redacted]	Age:	43	Sex:	FEMALE
Social Security:	[redacted]	Telephone:	[redacted]	Address	[redacted]		
City:	OAKVILLE	State:	CT	Zip:	06779		
E-Mail:	[redacted]						

SPOUSE:

Name:	[redacted]	Date of Birth:	[redacted]	Age:	53
Sex:	MALE	Social Security:	[redacted]		

CHILD:

Name:	[redacted]	Date of Birth:	[redacted]	Sex:	MALE	Age:	19

CHILD:

Name:	[redacted]	Date of Birth:	1[redacted]	Sex:	MALE	Age:	13

ANSWER THE FOLLOWING MEDICAL HISTORY QUESTIONS:
Please answer the following questions completely and accurately:

Any material misstatements or omissions of information made on this form will be considered a misreprentation and may be the basis for later recission of my coverage and that of my dependents. In the event of recission or termination for any reason, the insurer shall have the right to deduct any premium due and unpaid from any claims payable to me or my dependents.

1. Will there be any other health insurance in force on the policy date?
   NO
2. Is the proposed insured, spouse, or any dependent child now pregnant?
   NO
3. Has any person applying for coverage been declined for health insurance for a condition that is still present? (Missouri residents do not have to answer)
   NO
4. Is any proposed insured currently eligible for Medicaid?
   NO
5. Are you or any person proposed for coverage over 300 pounds if male or over 250 pounds if female?
   NO
6. Within the past 5 years have you or any person proposed for coverage been aware of, received an abnormal test report, been diagnosed with, treated by or received follow-up care with a member of the medical profession or taken medication for heart disorder including but not limited to heart attack, stroke, cancer, tumor, emphysema or COPD (chronic obstructive pulmonary disease), diabetes, liver disorder, kidney disorder other than stones, degenerative disc disease or herniated disc, rheumatoid or psoriatic a rthritis, degenerative joint disease of the knees or hips, alcohol abuse or chemical dependency, hemophilia?
   NO
7. Have you or any person proposed for coverage been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex, or any other immune system disorder? Answer this question "no" if you have tested positive for HIV but have not dev eloped symptoms of the disease AIDS.
   NO
8. Has any person proposed for coverage not been a legal resident of the United States for the last 12 consecutive months?
   NO

NOTE: IF YES IS ANSWERED ON ANY QUESTION 1 THROUGH 7 COVERAGE CANNOT BE ISSUED.

1) I agree that coverage will not become effective for any person whose medical history changes prir to coverage approval such that the person s answer would be YES to any of the Medical History questions in this application. If such person is the Applicant coverage is automatically declined for all persons included in this application. 2) I hereby request coverage under the policy issued to thegroup policyholder by the insurer and understand that if the coverage applied for becomes effective I agree to all the terms of the group policy. I understand that health insurance benefits are excluded for pre-existing conditions. 3) I understand that the broker who solicited this application was cting as an independent contractor and not as an agent of the Insurance Company. I further acknowledge that the person who solicited this application and upon whose explanation of benefits limitations or exclusions we relied was retained by me as my agent and that such person has no right to bind or approve coverage or alter any of the terms or conditions of the policy. 4) I have read this appliction and have verified that all of the information provided in it is complete true and correct and is all within my personal knowledge. I agree to immediately notify the insurer of any changes in any of the information contained in this form which may

occur prior to the approval of coverage. 5) Allinformation provided will be held in strictest confidence. Your personal health information is protected at all times and may only be released with your express written authorization to do so. Fraud Warning: Any person who with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a claim containing a false or deceptive statement or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties. Arkansas Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant. Kentucky Ohio and Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act which is a crime. New Mexico Residents: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES. Oklahoma Residents: WARNING: Any person who knowingly and with intent to injure defraud or deceive any insurer makes any claim for the proceeds of an insurance policy containing any false incomplete or misleading information is guilty of a felony. Tennessee Residents: It is a crime to knowingly provide false incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment fines and denial of coverage.

Fraud Warning: Any person who with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a claim containing a false or deceptive statement or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties. Arkansas Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant. Kentucky Ohio and Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act which is a crime. New Mexico Residents: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES. Oklahoma Residents: WARNING: Any person who knowingly and with intent to injure defraud or deceive any insurer makes any claim for the proceeds of an insurance policy containing any false incomplete or misleading information is guilty of a felony. Tennessee Residents: It is a crime to knowingly provide false incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment fines and denial of coverage.

Signature of Applicant:	[redacted]	Date: 06/07/2007
Signature of Spouse:	[redacted]	Date: 06/07/2007
SSL-STM-0506-APP-CT	STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK	

For Agents Use Only:

Agent Name: HEALTH BENEFITS DIRECT 2

HPA Code: X0121701001

Premium Totals:

Plan Cost: $262.84

Enrollment Fee: $100.00

State of Connecticut

THOMAS R SULLIVAN
INSURANCE COMMISSIONER

P O BOX 816
HARTFORD CT 06142-0816

Hartford

September 4, 2008

Kevin Lembo
Healthcare Advocate
Office of the Healthcare Advocate
PO Box 1543
Hartford, CT 06144

RE: Your letter of July 23, 2008

Dear ~~Mr. Lembo~~ Kevin:

I have reviewed your letter of July 23, 2008 replying to my response to your July 3, 2008 letter asking for changes to the Connecticut Insurance Department ("Department") Bulletin HC-66 regarding application of Conn. Gen. Stat. §38a-477b and the interpretation of that statute as published in Bulletin HC-66 ("Bulletin"). I appreciate this opportunity to respond to your concerns and provide further clarification regarding Public Act 07-113 and Bulletin HC-66

I note in your recent testimony before Congress[1], you reported the number of complaints regarding pre-existing condition limitations and claim denials, as well as rescissions, has seen substantial improvement and reduction in incidence. We believe this reflects evidence that the law, as interpreted and enforced, is creating the behavioral change we intended with its enactment.

The Department, as the statutory regulator of insurance practices in Connecticut, continuously monitors insurer and health care centers conduct and compliance with the insurance laws, including Conn. Gen. Stat. §38a-477b. Therefore, in order to further satisfy myself that the law has resulted in the needed change in practice, and allay any concerns that you may have, I will initiate a data call, under the authority granted to this department through our market conduct review, to sample carrier compliance with Conn. Gen. Stat. §38a-477b. When we have completed our review, we will be happy to share our overall determination as to the industry's performance.

With respect to the ConnectiCare case you referenced in your letter, let me assure you that the case was thoroughly reviewed which included a discussion with ConnectiCare. Our determination is that ConnectiCare did, pursuant to Conn. Gen. Stat. §38a-477b ,

[1] July 17, 2008 testimony of Kevin Lembo before the House Committee on Oversight and Government Reform

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

The facts of the situation are:

The [redacted] applied for an individual health insurance policy from ConnectiCare on December 14, 2006. Based on the processes in place at the time, ConnectiCare accepted the application and issued a policy to the [redacted] for a January 1, 2007 effective date. This was prior to the enactment of Public Act 07-113 later codified as Conn Gen. Stat. §38a-477b.

The application contains a long form medical questionnaire which indicates that the only conditions to which [redacted] responded in the affirmative were those dealing with a history of 1) smoking and 2) neck problems. As a result of the affirmative answers, [redacted] was asked to provide additional medical information regarding her neck condition and was asked for the names of the treating physician to enable ConnectiCare to obtain additional information/medical records. The medical records are stamped as being received by ConnectiCare on December 15, 2006 which indicates that ConnectiCare obtained the additional information on a timely basis prior to the effective date of policy (January 1, 2007) which could have afforded them time to not issue the policy if they had been fully aware of [redacted] complete medical background. The ConnectiCare investigation was limited to clarifying questions reasonably related to [redacted] neck condition, they did not look for collateral issues for which no indication had been given.

[redacted] specifically responded in the negative to questions dealing with liver disorders and whether she had sought medical treatment for conditions or disorders not listed in the application. As a result of those responses, no additional investigation was conducted until ConnectiCare received charges on October 17, 2007 for medical testing on or about August 31, 2007 which raised questions of inconsistency regarding [redacted] medical history as presented on the application. At that time, ConnectiCare initiated an investigation requesting medical records which they received on January 14, 2008 from Dr. Kelley, on February 8, 2008 from Dr. Cipolla, and February 18, 2008 from Dr. Anastasia; these records indicated [redacted] had been tested for and diagnosed with a liver disorder in 2006 in spite of her having responded in the negative on her insurance application to whether she had sought treatment for any of these disorders. The testing and diagnostic examinations for liver function, gallbladder disease and frequent heartburn in August and September 2007 were directly related to the earlier testing. On March 3, 2008, ConnectiCare advised Ms. [redacted] that her coverage was being rescinded because it determined that material medical information which would have impacted ConnectiCare's underwriting determination was omitted from her application for insurance.

Conn. Gen Stat §38a-477b provides in relevant part that:

(a) Unless approval is granted pursuant to subsection (b) of this section, no insurer or health care center may rescind, cancel or limit any policy of insurance, contract, evidence of coverage or certificate that provides coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 on the basis of written information submitted on, with or omitted from an insurance application by the insured **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**. No insurer or health care center may rescind, cancel or limit any such policy; contract, evidence of coverage or certificate more than two years after the effective date of the policy, contract, evidence of coverage or certificate. **(emphasis added)**

The general process utilized by ConnectiCare to underwrite individual health insurance policies is as follows:

- Upon receipt of an application, any affirmative answers are investigated in full which includes obtaining medical records from all providers which were involved in the diagnosis or treatment of the identified medical condition
- If the records disclose no further medical history or inconsistencies, the underwriting investigation is considered complete and action is taken upon the application
- If the records received above also indicate other medical history not identified or disclosed on the application, or inconsistent with the application, additional medical records dealing with those conditions will be obtained and reviewed before the action is taken upon the application
- If the application is accepted following the above medical underwriting investigation, and a claim is presented within the first two years from the date of the application which indicates an inconsistency with the statements made on the application, a medical underwriting investigation is undertaken. Based on that review, a policy may be recommended for rescission

Medical underwriting standards used are a combination of commercially available and proprietarily developed guidelines

Notwithstanding that the policy was issued prior to the effective date of PA 07-113, ConnectiCare did in fact complete 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. The file clearly evidences that based upon the written information on the application, ConnectiCare conducted an investigation of the medical information which was disclosed, no information was provided in those obtained additional records, or the application itself, which would have raised any ***reasonable medical questions*** indicating the need to investigate liver, gallbladder or other conditions not disclosed. Indeed, if ConnectiCare had in fact sought full medical records without a specific causal investigatory link, I believe they would have been subjecting themselves to allegations that they were fishing for adverse medical conditions/history as an attempt to exclude a variety of pre-existing conditions

Your July 3, 2008 letter claims that ConnectiCare failed to comply with the existing guidance requiring it to submit evidence to the Department of presale underwriting when an insured has made a complaint I have verified that [redacted] never filed a complaint with

the Insurance Department. Lacking such a complaint filed with the Department, it would have been impossible for ConnectiCare to comply with the requirement that it submit evidence to the Department that presale underwriting was completed as required.

My determination is that ConnectiCare did perform presale medical underwriting (even though the policy was issued prior to the enactment of PA 07-113) and therefore was not required to receive my permission to rescind a policy which was issued based on material omissions of information.

With respect to your specific requests of July 23, 2008, it would be inconsistent with the law and the Bulletin to remind insurers and health care centers that each and every case in which an insurer seeks to rescind, cancel or limit a policy requires a submission of the case to the Department to determine whether the underwriting process is complete prior to the insurer canceling, rescinding or limiting the policy, if the carrier claims to have completed medical underwriting in advance of issuing the policy.

Since there is no evidence that insurers or health care centers are not in compliance with the law or the Bulletin, I do not think it is appropriate to clarify that a determination by the Department that underwriting was not completed for a specific policy, or a carrier's admission that underwriting was not completed, will trigger the prior approval process before a rescission, cancellation or limitation can occur.

At this time, I do not think it is necessary to issue specific standards or guidelines to Department staff that review whether insurers or health care centers are complying with the law or Bulletin. These determinations are based on applicable law, contracts, and relevant facts to each and every situation by individuals knowledgeable in the statutes, law, and insurance practices. I believe it is best to review each situation on its own merits and facts.

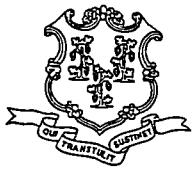
Finally, I believe that the information contained in Bulletin HC-66 is clear and provides sufficient guidance to the industry and do not find it necessary to include the information contained in Bulletin HC -69.

Again, I appreciate this opportunity to provide further clarification of Public Act 07-113 and our Bulletin that provides guidance to the industry regarding the implementation of this landmark legislation. I believe the interpretation of Conn. Gen. Stat. §38a-477b as I have published in Bulletin HC-66 is accurate and appropriate. It balances my obligations to make sure that licensed entities are complying with the enacted law while at the same time ensures that there is a competitive and meaningful marketplace in Connecticut which provides as much access as possible to health insurance choices.

As always, I welcome your comments and look forward to continued dialogue on important public policy issues of mutual concern.

Sincerely,

Thomas R. Sullivan
Commissioner



STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Testimony of the Connecticut Insurance Department

Before the

Insurance and Real Estate Committee

February 24th, 2009

Raised Bill 6531 – An Act Clarifying Post Claims Underwriting

The Connecticut Insurance Department would like to offer the following comments in opposition to Raised Bill 6531--An Act Clarifying Post Claims Underwriting. This proposal makes numerous changes to the existing law on post claims underwriting to address problems that the Department believes do not exist, primarily due to the passage of Public Act 07-113. While Connecticut never had a significant problem with rescissions of health insurance policies, as did a state like California, we have had our share of problems with pre-existing condition claim denials. Due to the enactment of PA 07-113, An Act Concerning Post Claims Underwriting, along with the Department's highly publicized enforcement action against Assurant that resulted in a $2.1 million fine and $900,000 in restitution to consumers, considerable change has occurred in the marketplace leading to a reduction in improper conduct.

Raised Bill 6351 proposes a number of changes to a law that is slightly less than 18 months old and has shown itself to successfully curb the problem of post-claim underwriting denials and rescissions. In addition, Connecticut's law has served as a model to other states, such as California and Maryland, that have adopted some of its provisions to address the problems of pre-existing condition denials and rescissions.

The Department believes that the following data may be useful as you consider Raised Bill 6531. For the period of October 1, 2007 to September 30, 2008, the first year following the implementation of the law, 32,950 individual health insurance policies were written in Connecticut. Of all those policies, fifty-two were rescinded without prior approval of the Department; that is, less than 1/10th of 1% of all these policies. Theses policies were issued pursuant to the insurer or health care center having completed medical underwriting and resolving all reasonable medical questions on the application. By way of background, carriers are required to seek permission from the Department to rescind a policy ONLY in those instances when they have NOT conducted pre-sale underwriting. Testimony on July 17, 2008, before the US House Committee on Oversight and Government Reform reflected that the number of complaints in Connecticut regarding pre-existing condition limitations and claim denials, as well as rescissions, has seen substantial improvement and reduction in incidence.

During that same time period, the Insurance Department has received a total of seven (7) consumer complaints claiming unjustified post claim underwriting. Our review of those

complaints found that in six of the instances, the consumer failed to disclose material medical history on the insurance application. Again, in that same period, the Department has received four (4) requests for prior approval to rescind individual medical policies where insurers identified information through claim processing which contradicted the medical application and therefore had reason to investigate whether the information submitted on the application had been complete or truthful. In all four requests, the Department has approved the rescission after finding that in each case, the consumer had either submitted written information on the application that was false at the time the application was made, or they should have known of the information or may have knowingly omitted the information.

In addition, compliance with this law is now an element of review for our Market Conduct Examinations and no companies having undergone market conduct exams since the implementation of the law have been found to be out of compliance.

The bill as proposed has serious flaws. We will not take your time to identify each of them, although we would be happy to provide a section by section analysis of the Department's concerns, but we do want to point to a few significant issues:

- The bill seeks to have insurers and carriers obtain prior approval for all rescissions, cancellations and limitations, no matter what steps they have taken on a presale basis. As currently written, that would also draw in cancellations for non-payment of premium or loss of eligibility.

- The bill seeks to absolve the applicants for any responsibilities for statements made on the application. It is unclear how that is reconciled with the requirement that applicants attest that they have read and certify the information is true and correct on each application.

- The bill seeks to restrict insurers to using a single, uniform application, designed by the Insurance Department, the Attorney General's Office and the Healthcare Advocate's Office for all lines of business. As drafted, this would require that property and casualty lines, as well as life, annuity, and health would use the same application. That is an overly burdensome and anti-competitive.

Applications are not crafted in isolation, but rather are reflective of the companies' respective product designs and underwriting guidelines, which reflect the companies' respective risk capabilities and business strategies. To require all companies to use the same application would cause the market to coalesce and may result in reduced market offerings, less product and underwriting innovations and may have the effect of shutting new companies out of the market. If all the companies have the same underwriting standards, then an applicant denied by one company has no chance of acceptance by a second company if they are evaluating on the same basis. Rather than protecting consumers, this further reduces access.

We urge the Committee to reject this proposal. Connecticut's post-claims underwriting law is relatively new and appears to be working as intended without any disruption to Connecticut's individual marketplace. The law is seen as a national model and any changes at this time are premature. The Department will continue to monitor compliance with the law and will certainly recommend any changes in the future.