



SOCIETY OF ACTUARIES

**Individual and Small Group Health
Insurance Underwriting Seminar
September 18- 19, 2008**

**Session # 2: Panel- Pre-Ex/Post- Issue
Underwriting**

**Sue Nelson
Mindy Stadel
J. P. Wieske
Kip May**

**Moderator:
Kip May**

POST ISSUE

- **Pre-Existing Limitation**
- **Misrepresentation**

1

PANEL MEMBERS

Kip May
Sue Nelson
Mindy Stadel
J.P. Weiske

2

Overview of Discussion

Post issue: How do we combat anti-selection?

- Identification
- Evaluation
- Recommendations

Carrier Perspective

Politics of Rescission

Litigation, Market Conduct, Safe Harbor

3 Wrap up/ Q&A

POST ISSUE: How do we combat anti-selection?

INDUSTRY BEST PRACTICES

IDENTIFICATION: *Medical Health Reviews*

Purpose: Observation of routine back-end processes to gain understanding of what drives investigations for pre-ex and potential misrepresentation.

5

IDENTIFICATON cont.

- Are ID processes manual or electronic?
- Who or what department handles investigations?
- Does process involve claim approver consideration &/or routing to another area?
- What criteria drives identification?
- Once identified, at what point and who reviews original documents and initial underwriting requirements?
- Are RX claims linked to process?
- MHR process must co-exist with Prompt Pay Regulations.
- What documents are ordered and what look back period?

6

EVALUATION

Evaluating MHR's

7

EVALUATION cont.

- Is there a consistent practice in place?
- What is Company's margin of error when pursuing rescission?
- Does it appear Agent was involved?
- Are investigations driven off large \$ claim amounts?
- Can drug claims solely trigger investigations?
- Does it appear that misstatement of fact or misrepresentation of health was intentional?

8

EVALUATION cont.

- Is condition clearly one that would have led to a decline or max rate at time of initial underwriting decision?
- Are all claims pended once an investigation is initiated or just those related to the condition in question?

9

EVALUATION cont.

- Does the policy language and all supporting documents contain detailed language defining back end actions?
- Are underwriting guidelines reviewed prior to decision?
- What department is responsible for decision if risk is material or not and who handles the rescission action?

10

RECOMMENDATIONS

*Recommendations to
improve practices and
lessen litigation potential.*

11

RECOMMENDATIONS cont.

- UW upfront, not on backend!!!
- Must have consistent, table driven process driven off claim codes.
- Time frames should vary (pre-ex vs. misrep) and by significance of disorder.
- Establish tracking reports.
- Never pursue misrepresentation where errors in processing are identified.

12

RECOMMENDATIONS cont.

- If claims were paid out in excess of \$250 or \$300 on condition causing rescission, do not pursue.
- Courts have zero tolerance!
- Always get signed statement from agent.
- Medical Director involvement.
- Executive panel of independent reviewers to examine all 1st & 2nd level of appeals.
- Timely, accurate communication to insured members.

13

STATISTICS

14

STATISTICS:

- 1-2% rescission rate of total guaranteed renewable insured population.
- 15% of rescissions will be appealed one time. Some states allow insured to appear in person to appeal decision.
- 5% of rescissions will proceed to second appeal.
- 2% of rescissions end up in litigation.

15

**QUESTIONS will be addressed at
end of presentation.**

THANK YOU.

16

CARRIER PERSPECTIVE



17

Importance of Consistent Process



- Allows you to avoid bad faith allegations
- Avoid a process that is fragmented
- Set standards which meet or exceed the Unfair Claims Practice Act Standards

18

| SUMMARY OF UNFAIR CLAIMS PRACTICE ACT 2008 | | | | | | | | | |
|--|---------------------|---------------------------------------|---------------------------|----------------------------------|---------------------------------|---------------------|-----------------|---------------------------------|--|
| STATE | REGULATION | ACKNOWLEDGE | PROVIDE FORMS/ ASSISTANCE | RESPOND TO WRITTEN COMMUNICATION | AFFIRM OR DENY CLAIM | BEGIN INVESTIGATION | STATUS INSURED | PAYMENT OF "CLEAN" CLAIMS | PAYMENT OF INVESTIGATED CLAIMS |
| ALASKA | 21.36.128 | 30 DAYS NOTICE TO PROVIDER OR INSURED | 30 DAYS | 30 DAYS | 30 DAYS | 30 DAYS | 30 WORKING DAYS | 30 DAYS | 15 CALENDAR DAYS AFTER RECEIPT OF REQUIRED INFO |
| ARIZONA | 20-3102 | 30 DAYS NOTICE TO PROVIDER OR ENROLEE | 30 DAYS | 30 DAYS | 30 DAYS | 30 DAYS | 30 DAYS | 30 DAYS | 30 CALENDAR DAYS AFTER RECEIPT OF REQUIRED INFO |
| ARKANSAS | 43 S 12; 43 S 14 | 30 DAYS | 30 DAYS | 30 DAYS | ELEC=30 DAYS PAPER = 45 DAYS | 30 DAYS | 30 DAYS | ELEC=30 DAYS PAPER = 45 DAYS | 30 CALENDAR DAYS AFTER RECEIPT OF REQUIRED INFO |
| CALIFORNIA | 10123.47 | 30 WORKING DAYS | 15 DAYS | 15 DAYS | 30 WORKING DAYS | 30 WORKING DAYS | 30 WORKING DAYS | 30 WORKING DAYS | 30 WORKING DAYS AFTER RECEIPT OF REQUIRED INFO |
| COLORADO 19 | 10-16-106.5 | 10 WORKING DAYS | 15 DAYS | 30 DAYS | ELEC=30 DAYS PAPER = 45 DAYS | 30 DAYS | 30 DAYS | ELEC=30 DAYS PAPER = 45 DAYS | 30 CALENDAR DAYS IF ELECTRONIC; 45 CALENDAR DAYS IF PAPER |

Our Process....

- Critical data is extracted from submitted claims
- Electronic analysis of claims
- Factors considered include:
 - * Effective date for claimant
 - * Comparison of DOS to Effective Date
 - * Analysis of severity of the condition
 - * Diagnosis on submitted claims

Diagnosis sorting (system)

Explanation of the Sort Criteria

| Flag | Timeframe | Deductible=\$2500 or less | Deductible=\$2500 - \$5000 | Deductible of Greater than \$5000 |
|------|-----------|---------------------------|----------------------------|-----------------------------------|
| A | 2 years | \$100.00 | \$200.00 | \$300.00 |
| B | 1 year | \$125.00 | \$225.00 | \$325.00 |
| C | 9 months | \$125.00 | \$225.00 | \$325.00 |
| D | 6 months | \$150.00 | \$250.00 | \$350.00 |
| E | 3 months | \$175.00 | \$275.00 | \$375.00 |
| F | 1 month | \$175.00 | \$275.00 | \$375.00 |

21

Sample Diagnoses

- A = 2 yrs = AID's, some cancers, etc.
- B = 1 yr = diabetes, dysfunctions of the reproductive organs, etc.
- C = 9 mo = sciatica, neuritis, etc.
- D = 6 mo = tendonitis, pathological fractures, etc.
- E = 3 mo = chronic gastritis or tonsillitis, etc.
- F = 1 mo = otitis media, sinusitis, etc.

22

Additional Factors (Analyst)

- Claim history
- Disclosures on the application
- Disclosures during Health Questionnaire
- Possible pre-x credit
- Prior coverage

23

Processing Standards

- Review Possible Investigations within 5 days of receipt
- Review all files at minimum every 21 days
- Review Medical Records within 5 days of receipt
- Last record routes for immediate review

24

Undisclosed Health History

- Route to Underwriting to determine what action would have been taken.
- Correspondence to Insured to determine why this was not disclosed BEFORE taking any action.
- Committee review process—multi-disciplinary group.
- Correspondence to Agent when the Insured alleges the agent had knowledge or was told of a health history.

25

Know the State Requirements

- International Claims Association-
Misrepresentation in the Application
- Insurance Law Compendium-American Law Firm
Association (www.alfanet.org)
- Causal and Intent Requirements vary by State

26

Committee Review Process

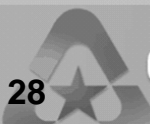
ALL cases reviewed by the UW Committee – a multi-disciplinary group

- Investigations are reviewed on terminated coverage to determine if reformation or rescission is warranted. This means many fewer rescissions on terminated cases.
- The claim diagnosis and exposure is now evaluated prior to reformation or rescission of coverage and the exposure to the carrier is evaluated in determining if adverse action is warranted. This means fewer actions on claims that do not present significant risk to our carriers.

27

The Politics of Rescission

J.P. Wieske
Council for Affordable Health
Insurance



28

**COUNCIL FOR AFFORDABLE
HEALTH INSURANCE**



Politicians, Interest Groups & The Press

- News story picked up by USA Today and others 1/2007 and after (USA Today has published at least 3 stories)
- Connecticut pushes and passes rescission reform fueled in part by press reports and failed health reform agenda
 - Insurers can not comment due to HIPAA privacy protections
 - Short term medical
 - Major medical rescission

29

Politicians, Interest Groups & The Press

- California
 - Foundation for Taxpayer and Consumer Rights (now ConsumerWatchdog.org) led charge
 - DMHC began revising rules and reviewing rescissions
 - One company admits paying bonuses for rescissions
 - Several pieces of legislation proposed
 - Los Angeles sues on behalf of rescinded residents

30

California Settlement

- Ongoing class action suits separate from state action
- Department of Managed Health Care looking at rescissions over past 5 years
- Working jointly with Insurance Department on new rules
- Has reached settlements with several carriers
 - Reinstate wrongly rescinded policies
 - Pay medical bills to \$15,000
 - Other costs through arbitration process

31

Proposed Policy Solutions

- States have proposed numerous solutions to the perceived problem:
 - Single-payer health insurance
 - Require guarantee issue and community rating in the individual market
 - Ban the ability of insurers to rescind coverage
 - Require insurance commissioner review of all rescissions
 - Require independent external review
 - Redefine misrepresentation as “intentional misrepresentation
 - Uniform application
 - Increased scrutiny on applications and market conduct examination

32

Likely Outcomes

- Most states have not seen major problems and may not take action
- Connecticut passed legislation requiring insurance department review of all rescissions
- New Mexico passed reform requiring that rescission include only intentional misrepresentations
- Other states will consider reforms
 - Focus on initial underwriting process
 - Clear and understandable application
 - No compensation based on claims denials or rescissions
 - Reliance issues
 - Limit rescissions to intentional misrepresentation
 - Independent External Reviews

33

Lessons Learned

- Single-payer advocates are using rescission as a rallying cry to push their legislative agenda
- Newspapers will publish one-sided stories despite unwillingness of plaintiffs to release the insurance company from HIPAA requirements
- Politicians see the issue as an opportunity to attack the insurance industry and the individual health insurance market
- Some health insurers do not know how to underwrite in the individual market and have used rescission to correct mistakes

34

Creating a Safe Harbor in the Misrepresentation and the Pre-Ex Process

Industry Best Practices

35

Safe Harbor

Pre-Ex and Post Issue Underwriting are valuable tools in Block and Rate Stability within the Small Group and Individual Markets.

- Identify and evaluate the availability/limitations by Jurisdiction for the use of Pre-Ex, Rescission, and Re-Rating or Retro Rate Actions.
- Underwrite upfront - but use all the tools available on Misrepresentation.
 - Pre-Ex
 - Rescission
 - Exclusion of Individual
 - Rider or Limitation Exclusion
 - Retro Rating in Small Group
- Evaluate the Routine Claims Review Process and specifically the BACKEND Process related to Misrepresentation.

36

Safe Harbor

- Review the Communication Process to Insurers
 - System Letters/Form Letters
 - Call Center Intake/Call referrals
 - Company Contact Individuals
- Attorney Letters
 - Who within the company responds
 - Notifying UW or Process Owner
 - Investigate for Errors
- Executive Management Buy-In/Commitment
 - Consistent use of Tools
 - Every Time – Reliance Issue
- Real Cost
 - System/Process vs. Jury Awards

37

Pitfalls – The Hidden Hazards

- Follow the Process Manual or Guidelines Every Time.
- The Process has fractured Ownership.
- Internal Audit seldom looks at the Process because of Multi-Departmental Collaboration.
- Call Center Staff responding to System Letter(s).
- System Letters don't fit or not totally complete.
- Multiple contact or respondents to Insurer.
- Reliance on State Market conduct Exam and Errors Ratios (not a defense).
- Failure to use Post Litigation Information.
(Review and Analysis of Cause of Litigation)
- Failure to Communicate –
 - Timelines
 - Inclusion of Agent/Broker
 - Inclusion of Legal/Litigation Staff
- Creating Reliance: A trial Lawyer favorite.

38

Mitigation

- Create Process Ownership and manage the entire process.
- Use MHR and Formal Internal Reviews with “Fresh Eyes.”
- Inclusion of Legal or Litigation Team in Reviews.
- Involvement of Medical Director in all Appeals.
- Use the people in the process that you want on the stand in Litigated Cases.
- Training and Instruction for Employees that will be or could be Deposed.
- Use all your Resources
- External Review for Medical Expertise.
- Outside Consultants for Expert Advice and Process.
- Trade Associations for Best Practices.
- Government Affairs for New Rules and Regulations.
- Include Litigation Climate in each state analysis when considering ROI on Markets.
- Learn from past mistakes – Fix the Process.

39

Questions for the Panelists

Sue Nelson
Mindy Stadel
J.P. Wieske
Kip May

40