REGULATORY FRAMEWORK (B) TASK FORCE

Regulatory Framework (B) Task Force Dec. 7, 2009, Minutes
- Regulatory Framework (B) Task Force Oct. 13, 2009, Conference Call Minutes (Attachment One)
  - Adopted 2010 Charges (Attachment One-A)
  - AHIP Comment Letter External Review Model Notices (Attachment One-B)
  - Uniform Health Carrier External Review Model Notices Oct. 13, 2009 (Attachment One-C)
- Draft Rescission Data Call Report Dec. 2, 2009 (Attachment Two)

Draft: 12/11/09

Regulatory Framework (B) Task Force
San Francisco, CA
December 7, 2009

The Regulatory Framework (B) Task Force met in San Francisco, CA, Dec. 7, 2009. The following Task Force members participated: Scott J. Kipper, Chair (NV); William W. Deal, Vice Chair, represented by Joan Krosch (ID); Jim L. Ridling represented by Steve Ostlund (AL); Steve Poizner represented by Bruce Hinze (CA); Kevin M. McCarty represented by Mary Beth Senkewicz (FL); Michael T. McRaith represented by Bob Wagner (IL); Carol Cutter represented by Doug Webber (IN); Mila Kofman represented by Bob Wake (ME); Glenn Wilson represented by Tammy Lohmann (MN); John M. Huff represented by Mary Kempker and Angela Nelson (MO); Monica J. Lindeen (MT); Ann Frohman represented by John Rink and Martin Swanson (NE); Roger A. Sevigny represented by Alex Feldvebel (NH); Mary Jo Hudson represented by Anne Jewel (OH); Joel Ario represented by Shelley Bain (PA); Merle D. Scheiber represented by Randy Moses (SD); Leslie A. Newman represented by LaCosta Wix (TN); Kent Michie represented by Tanji Northrup (UT); Alfred W. Gross represented by Jim Young (VA); Paulette Thabault represented by Christine Oliver (VT); Sean Dilweg represented by Fred Nepple (WI); and Jane L. Cline represented by Tim Murphy (WV). Also participating were: Peg Brown (CO); and Linda Sheppard (KS).

1. Adoption of Oct. 13, Conference Call Minutes

Mr. Hinze motioned, and Ms. Senkewicz seconded, to adopt the Oct. 13 conference call minutes (Attachment One). The motion passed unanimously.

2. CMS/DOL Discussion of Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Other Issues

Jim Mayhew (Centers for Medicare and Medicaid Services—CMS) said the federal agencies charged with implementing the federal Genetic Information and Nondiscrimination Act of 2008 (GINA) issued a notice of rulemaking Oct. 1 and published interim final regulations in the *Federal Register* Oct. 7. The regulations are effective Dec. 7 and have a Jan. 5, 2010, comment deadline. He urged state insurance regulators to contact CMS or the U.S. Department of Labor (DOL) if they have any issues with enforcement. Mr. Mayhew said he anticipates the regulations for the Mental Health Parity and Addition Equity Act of 2008 (MHPAEA) will be issued sometime in January 2010, with an effective date of July 1, 2010. He alerted the Task Force that CMS has received information from Families USA about consumers having problems receiving certificates of coverage from issuers once their COBRA coverage ends. Mr. Mayhew noted that issuers must provide the certificates. He said consumers should know that there are other ways for them to prove prior coverage when they do not receive a certificate of coverage. Commissioner Kipper encouraged CMS to reach out to state insurance departments to assist them in resolving issues with issuers not providing the required certificates of coverage. Ms. Senkewicz said her department was reviewing the interim final GINA regulations and asked whether the Task Force would be sending a comment letter. Jolie Matthews (NAIC) said, at this point in time, no decision has been made, but most likely, it would not. She requested that if any Task Force member decided to submit comments that they send a copy of the comments to her and she would circulate the comments to the Task Force.

3. Update on Survey Related to Individual Health Insurance Policy Rescission Decisions

Commissioner Kipper said at the Task Force's meeting at the Summer National Meeting, the individual health insurance policy rescission survey questions were finalized. Immediately after the Summer National Meeting, NAIC staff support for the Market Regulation and Consumer Affairs (D) Committee identified 52 companies in the individual market that made up the top 80% of covered lives and 75% of premium volume in the marketplace that should receive the data call, which was to be based on the survey questions. The 52 companies identified involved 25 states. On Aug. 28, an organizing conference call was held with these 25 states. During the call, it was agreed that the states would send the data call to their domiciliary companies during the first week of September, giving companies 30 days from the date of their letter to submit the requested data. The analysis of the data from the data call is reflected in the draft Rescission Data Call Report, dated Dec. 2 (Attachment Two).

Commissioner Kipper said he intended only to discuss and receive initial comments on the draft report during this meeting. He requested that additional comments be sent to NAIC staff. Commissioner Kipper said he anticipated that the Task Force would hold a conference call before the end of the year to consider those comments and discuss next steps. He reminded the Task Force that the purpose of the data call was to obtain a picture of what was going on in the marketplace regarding rescissions. Once that information was obtained, the Task Force was to decide if another more detailed survey was warranted.

Commissioner Kipper explained that the data call was divided into four parts. The first part of the data call asked companies for the number of individual health insurance policies or certificates issued on an individual basis written and in force and how many were rescinded in each state for the years 2004 to 2008. In the second part of the data call, the Task Force requested information on the underlying conditions that were the basis of the rescissions. The third part of the data call asked companies to provide information on their underwriting and rescission-making process. Finally, each company was asked to provide details on their rescission appeal process, if one was in place. Commissioner Kipper said the data call revealed that there were about 27,246 rescissions out of a sampling size of about 6.7 million issued policies. He said this translates into a rescission rate of 3.7 rescissions for every 1,000 policies/certificates that were written between 2005 and 2008. Commissioner Kipper noted that the data call also revealed that the rate of rescissions peaked in 2005 and was at its lowest in 2008.

Mr. Wake expressed concern with the language in the draft report's Executive Summary that seemed to imply that rescissions were not a problem. He suggested alternative language to resolve his concern. Mr. Wake also expressed concern with the quality of the data. He noted that Maine permits no medical underwriting, but the data showed two rescissions in Maine. He suggested that this might have been the result of the inclusion of short-term policies in the survey. Mr. Wake noted that the survey instructions carved out short-term policies (i.e. policies in effect for less than one year). However, Maine permits one-year short-term policies. Mr. Wake noted that if these types were inadvertently included, this could mean that the rescission rate is even lower than what was reported or that short-term policies should be examined in more detail in a separate data call. Mr. Nepple agreed with Mr. Wake's comments. Kevin Lucia (Georgetown Health Policy Institute) expressed agreement with Mr. Wake's comments. He said it seemed premature to indicate that rescissions were not a problem. Mr. Lucia urged the Task Force to pursue this issue further to obtain more information on why there are rescissions. Sally McCarty (National Hemophilia Association) agreed with Mr. Lucia's comments. Commissioner Kipper reiterated his intent to hold a conference call prior to the end of the year. He suggested that the Task Force members be prepared to recommend a course of action, which could include adopting the report and concluding its examination of this issue or delving deeper into the analysis.

4. ERISA (B) Subgroup Report

Mr. Nepple reported that the ERISA (B) Subgroup met in regulator-to-regulator session to discuss ongoing federal and state investigations into unauthorized MEWAs in accordance with the NAIC Policy Statement on Open Meetings. Mr. Nepple motioned, and Mr. Wake seconded, to receive the ERISA (B) Subgroup report. The motion passed unanimously.

Having no further business, the Regulatory Framework (B) Task Force adjourned.

W:\Dec09\TF\RF\12-RFTF.doc

Drafted: 11/3/09

Regulatory Framework (B) Task Force
Conference Call
October 13, 2009

The Regulatory Framework (B) Task Force met via conference call Oct. 13, 2009. The following Task Force members participated: Scott J. Kipper, Chair (NV); Steve Poizner represented by Bruce Hinze (CA); Kevin McCarty represented by Eric Lingswiler (FL); Michael T. McRaith represented by Bill McAndrew (IL); Carol Cutter represented by Anita Strauss (IN); Mila Kofman represented by Bob Wake and Norm Stevens (ME); John M. Huff represented by Angela Nelson (MO); Monica J. Lindeen (MT); Ann Frohman represented by John Rink (NE); Mary Jo Hudson represented by Anne Jewel (OH); Teresa Miller (OR); Joel Ario represented by Shelley Bain (PA); Merle D. Scheiber represented by Melissa Klemann (SD); Leslie A. Newman represented by Shawn Hawk (TN); Alfred W. Gross represented by Ann Colley (VA); Paulette Thabault represented by Sean Londergan (VT); Sean Dilweg represented by Fred Nepple (WI); and Jane L. Cline (WV). Also participating were: Peg Brown (CO); and Linda Sheppard (KS).

1. Adoption of Task Force 2010 Charges

Jolie Matthews (NAIC) reviewed the Task Force's 2010 Proposed Charges. She noted that the changes from the Committee's 2009 adopted charges were technical. Commissioner Kipper asked whether potential federal health care reform legislation would impact the Task Force's activities in 2010. Ms. Matthews said there was a distinct possibility that such legislation would have such an impact. She said the Task Force's 2010 Proposed Charges were broad enough to include any work that the Task Force may have to do in relation to such legislation. Mr. Lingswiler motioned, and Mr. Nepple seconded, to adopt the 2010 Proposed Charges (Attachment One-A). The motion passed unanimously. Florida, Nevada and Pennsylvania agreed to sponsor the 2010 Proposed Charges.

2. CMS/DOL Discussion of Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Other Issues

Jim Mayhew (Centers for Medicare and Medicaid Services—CMS) updated the Task Force on the status of CMS' review of state alternative mechanisms for compliance with HIPAA's market reform requirements. CMS is sending letters only to those states that have made significant changes to their alternative mechanisms since the last review. Commissioner Kipper asked if CMS would be willing to share the results of its review. Mr. Mayhew said CMS would share those results. He noted that one common issue has arisen in CMS' reviews. States have neglected to indicate that coverage under the federal State Children's Health Insurance Program (SCHIP) is creditable coverage. He said that after CMS raises this issue with a state, the state readily agrees and corrects the problem. Mr. Rink said CMS had raised this issue with his state. He said Nebraska's law includes a reference to a public health plan insurance option as being creditable coverage, which, in his opinion, would include SCHIP. He said this reference has been in the Nebraska law for a number of years and asked why CMS was now raising this issue. Mr. Mayhew said CMS would consider SCHIP to fall within the meaning of a public health plan insurance option. CMS raised the issue because it wanted to make sure Nebraska was recognizing SCHIP as a public health plan insurance option.

Ms. Matthews updated the Task Force on the NAIC/CMS survey on state implementation of the Genetic Nondiscrimination Act of 2008 (GINA) and the Mental Health Parity and Addition Equity Act of 2008 (MHPAEA). GINA prohibits the denial, conditioning or discrimination in the pricing of a group or individual health plan on the basis of genetic information. GINA also limits the ability of group health plans and group and individual health plan issuers to request or require genetic testing, and prohibits the collection of genetic information for underwriting or other purposes prior to enrollment. MHPAEA requires group health plans for businesses with 50 or more employees to provide care for mental health and substance abuse disorders that is on par with other covered medical conditions. MHPAEA does not apply to the individual or small group markets. Ms. Matthews said the survey was distributed to NAIC members on July 23, with a deadline of Sept. 4 to submit the requested information. To date, she has received 39 responses. Ms. Matthews said that for the GINA survey questions, some states referred to their state implementation activities taken for Medicare supplemental plans instead of for group health plans. She said she planned to follow up with these states. Mr. Mayhew encouraged those states that have not yet responded to the survey to do so. He said CMS plans to use the survey results to ascertain state implementation of these federal laws.

Ms. Matthews noted that the federal agencies charged with implementing GINA issued a notice of rulemaking on Oct. 1 and published interim final regulations in the *Federal Register* on Oct. 7. The regulations are effective Dec. 7 and have a Jan. 5, 2010, comment deadline. Mr. Mayhew said the regulations for MHPAEA have been delayed. MHPAEA required the

regulations to be issued by Oct. 3. He anticipates the regulations being issued by January 2010.

3. Update on Revisions to NAIC Models Related to GINA and SCHIP

Ms. Matthews said drafts of NAIC models revised for consistency with GINA and the special enrollment provisions under the SCHIP Reauthorization bill were distributed for comment June 5 (see Attachments Two, Three and Four of the Regulatory Framework (B) Task Force minutes, 2nd Quarter 2009 *Proceedings*). Comments were requested on these drafts by July 17. She said no comments were received. Rather than moving forward, Ms. Matthews suggested that the Task Force hold these drafts in anticipation of additional revisions that may be necessary in light of the recently issued GINA regulations and the enactment of federal health care reform legislation. She said some of the provisions in the federal health care reform legislation currently being considered would require the NAIC to revise these models or scrap them altogether. After discussion, the Task Force agreed to this suggestion.

4. Discussion of Comments Received on External Review Model Notices

Ms. Matthews said the recently adopted Uniform Health Carrier External Review Model Act (#76) contemplates the Task Force developing and adopting a number of model notices, including a model notice related to the right to request external review and a model notice for requesting an external review. She said that following the Summer National Meeting, she distributed revised drafts of these model notices for comment. The revisions reflected the discussion at that meeting. She said the only comments received were from America's Health Insurance Plans (AHIP) (Attachment One-B).

Ms. Matthews said that in reviewing AHIP's comments, she would suggest that the Task Force accept the comment that corrects a drafting error in the draft model Health Carrier External Review Annual Report Form. As currently drafted, it contains the word "annual" two times in the title. AHIP suggests deleting one of those references. Ms. Matthews explained the remaining AHIP comments. With respect to AHIP's comment to consolidate the bullets under reasons for denial in the draft Model Notice of Appeal Rights, Jeff Garbardi (AHIP) said this revision would streamline the process. Ms. Matthews said AHIP suggests revising the draft Model External Review Request Form to include two additional reasons for a denial of a requested or recommended health care service or treatment: 1) the health care service or treatment is not covered by the health benefit plan; and 2) the individual receiving the service is not covered by the health benefit plan. Ms. Matthews said Section 8—Standard External Review in the Uniform Health Carrier External Review Model Act (#76) requires the health carrier to consider these reasons for the denial when making an initial determination on whether the external request is eligible for full external review. Mr. Garbardi said including these two additional reasons would expedite the process.

Ms. Matthews said AHIP suggests revising the physician certification related to experimental/investigational denials in the draft Model External Review Request Form to require the physician to detail what studies he or she relied upon to support the recommended or requested health care service or treatment. Mr. Garbardi said requiring this information would save time. Mr. Mayhew noted that including such information would not be appropriate in all cases. Ms. Matthews said AHIP suggests revising the draft Model Independent Review Organization External Review Annual Report Form to identify the state insurance commissioner to whom the report is to be sent. She noted that the draft reporting form already includes references to the state insurance department to which the form should be submitted. As such, including AHIP's suggested revision could be duplicative. Ms. Matthews said that, in addition to its previous comment concerning the word "annual," AHIP also suggests revising the draft model Health Carrier External Review Annual Report Form to require health carriers to provide information on the number of external review requests upheld and overturned. Mr. Garbardi said requiring this information to be included would help to ensure that consistent data is being collected by independent review organizations and health carriers. Ms. Matthews said Section 15—External Review Reporting Requirements in the Uniform Health Carrier External Review Model Act (#76) allows the commissioner to request any other information the commissioner considers necessary. Mr. Garbardi said specifically including the requirement to report this information in the form itself would ensure uniformity.

Mr. Rink motioned, and Ms. Nelson seconded, to accept AHIP's suggested revision for removing the first "annual" in the draft model Health Carrier External Review Annual Report Form. The motioned passed unanimously. Mr. Rink motioned, and Mr. Hinze seconded, to adopt the model notices as revised (Attachment One-C). The motioned passed unanimously. Commissioner Kipper said the draft model notices and forms will be considered for adoption by the Health Insurance and Managed Care (B) Committee at the Winter National Meeting.

5. Update on Individual Health Insurance Policy Rescission Survey

Jennifer Cook (NAIC) said that at the Task Force's meeting at the Summer National Meeting, the individual health insurance

policy rescission survey questions were finalized. Immediately following the Summer National Meeting, NAIC staff for the Market Regulation and Consumer Affairs (D) Committee identified 52 companies in the individual market that made up the top 80% of covered lives and 75% of premium volume in the marketplace that should receive the data call, which was to be based on the survey questions. Ms. Cook said the 52 companies identified involved 25 states. On Aug. 28, an organizing conference call was held with these 25 states. During the call, it was agreed that the states would send out the data call to their domiciliary companies during the first week of September giving companies 30 days from the date of their letter to submit the requested data. After a state receives the data, it would forward that data to the NAIC. Ms. Cook said the NAIC has received data from several companies and requests for extensions of time from others. She said it is anticipated that a preliminary report regarding the survey will be presented at the Task Force's meeting at the Winter National Meeting. David Korsh (BlueCross and BlueShield Association—BCBSA) asked whether interested parties could obtain a list of the companies involved in the data call. Ms. Cook said she believed that information was confidential, but she would ask NAIC staff handling the data call. Mr. McAndrew asked about the status of the confidentiality agreement he had requested for Illinois. Ms. Cook explained that some states have concluded that they do not need a specific confidentiality agreement with the NAIC for this data call. Others, however, such as Illinois, have decided that such an agreement is necessary. She said she would contact Randy Helder (NAIC) to determine the status of Illinois' confidentiality agreement and follow up with Mr. McAndrew.

6. ERISA Subgroup Report

Mr. Nepple reported that the ERISA Subgroup met in regulator-to-regulator session to discuss ongoing federal and state investigations into unauthorized MEWAs in accordance with the NAIC Policy Statement on open meetings. Mr. Wake motioned, and Mr. Lingswiler seconded, to receive the ERISA Subgroup report. The motion passed unanimously.
Having no further business, the Regulatory Framework (B) Task Force adjourned.

W:\Dec09\TF\RF\10-13-09 RFTF confcallmin.doc

Draft: 10/13/09

REGULATORY FRAMEWORK (B) TASK FORCE

The mission of the Regulatory Framework (B) Task Force is to develop NAIC model acts and regulations for state health care initiatives, and ~~with considering~~consider policy issues affecting state health insurance regulation.

Ongoing Maintenance of NAIC Programs, Products and Services

1. Review model laws adopted in ~~2004~~2005 and recommend whether they be retained, revised or deleted. Report by ~~2009~~2010 Winter National Meeting~~;~~. *Essential*

2. Review and revise, as necessary, NAIC model laws and regulations identified as in need of review and revision as a result of the NAIC model law review initiative. Report annually~~;~~. *Important*

3. Consider the revision of NAIC model laws and regulations affected by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and final federal regulations promulgated pursuant to HIPAA to comport with the requirements of HIPAA and final federal regulations. Report quarterly~~;~~. *Important*

4. Develop a Model Regulation to Implement the Small Employer and Individual Health Insurance Availability Model Act (Prospective Reinsurance With or Without an Opt-Out), once final federal regulations are issued. Report by ~~2009~~2010 Winter National Meeting~~;~~. *Important*

5. Revise the *Model Regulation to Implement the Small Employer Health Insurance Availability Model Act (Prospective Reinsurance With or Without an Opt-Out)* (#119) and the *Model Regulation to Implement the Individual Health Insurance Portability Model Act* (#38) to comport with revisions to the model acts once final federal regulations are issued. Report by ~~2009~~2010 Winter National Meeting~~;~~. *Important*

6. Consider the revision of NAIC model laws and regulations affected by the Genetic Information Nondiscrimination Act of 2008 (GINA) and any final federal regulations promulgated pursuant to GINA. Report by ~~2009~~2010 Winter National Meeting~~;~~. *Important*

7. Study proposals for developing a process for the independent review of policy rescission decisions for individually underwritten health insurance and preexisting condition exclusion decisions. ~~and~~ Consider the different approaches that ~~may~~could be used to establish this independent review process and identify and evaluate the issues associated with such a process. Report by ~~2009~~2010 Winter National Meeting. *Important*

New Objectives and Goals

1. Review issues concerning the standardization of forms practices and procedures in health insurance underwriting with respect to regulatory modernization that promotes administrative efficiency and the reduction of associated costs. Report by ~~2009~~2010 Winter National Meeting~~;~~. *Important*

Sponsors for 2010 Charges
(Except as noted, I support all charges)

Kevin McCarty	**Scott J. Kipper**	**Joel Ario**
Florida	**Nevada**	**Pennsylvania**

Staff Support: Jolie H. Matthews/Jennifer R. Cook

w:\Dec09\TF\RF\chrg2010 RFTF adopted.doc

America's Health Insurance Plans

601 Pennsylvania Avenue, NW
South Building
Suite Five Hundred
Washington, DC 20004

202.778.3200
www.ahip.net

28 August 2009

Honorable Scott Kipper
Commissioner of Insurance
State of Nevada
788 Fairview Drive, Suite 300
Carson City, Nevada 89701-5491

RE: External review forms – exposure draft 3

Dear Commissioner Kipper:

America's Health Insurance Plans (AHIP) appreciates the opportunity to provide additional comments and information on the revised draft forms for use with the NAIC's *External Review Model Act*. AHIP is the national trade association representing the private sector health insurance industry. AHIP's nearly 1,300 member companies provide health, long-term care, dental, disability, and supplemental coverage to more than 200 million Americans. We have some comments and suggestions about the newly exposed documents.

I. Notice of Appeal Rights

We note that the first three bullets under the reasons for denial are somewhat redundant. We suggest that they may be condensed into one bullet as follows:

- Do not understand why a request for a health care service or treatment was denied or not fully covered;

II. External Review request form

We suggest that under the section entitled "Reason for health Carrier Denial" the following two reasons be included: "The health care service or treatment is not covered by the health benefit plan" and "The individual receiving service is not covered by the health benefit plan."

III. Appointment of Authorized Representative

No comment.

IV. Health Care Service or Treatment Decision in Dispute

No comment.

V. What to Send and Where to Send It

No comment.

VI. Certification of Treating Health Care Provider For Expedited Consideration Of A Patient's External Review Appeal

No Comment.

VII. Physician Certification: Experimental/Investigational Denials

We suggest that if in #5 on this form, the treating physician were requested to detail the references of studies upon which his certification is based, significant time could be saved in deciding the appeal.

VIII. Independent Review Organization External Review Annual Report Form

No comment

We suggest that it identify the [state commissioner] to whom it is to be directed at the beginning of the document.

IX. Health Carriers Annual External Review Annual Report Form

We suggest that the first "Annual" be removed from the title.

In addition, we also suggest that it would be beneficial to add the number of external review requests upheld and overturn in the attachment, which would assist the state in ensuring that consistent data is being collected by the IROs and the health plans.

We thank you for the opportunity to provide comments on the standard external review forms and look forward to discussing these issues with you further in the near future. If you have any questions or comments please do not hesitate to contact me. I may be reached at (301) 774.2268 or at rreichel01@comcast.net

Thank you.

Randi Reichel

W:\Dec09\TF\RF\AHIP Comments ExtRevForms 08-09.doc

Draft: 10/13/09

Model 76

Adopted by the Regulatory Framework (B) Task Force, 10-13-09

Underlining and overstrikes show the changes from the existing model. Please note that the appendices contain all new language. Comments should be sent by email to Jolie Matthews at jmatthew@naic.org.

UNIFORM HEALTH CARRIER EXTERNAL REVIEW MODEL ACT

Table of Contents

Section 1. Title

This Act shall be known and may be cited as the Uniform Health Carrier External Review Act.

Drafting Note: In some States existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act as a regulation. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as a regulation.

*****

ALL NEW LANGUAGE

Appendix A – Model Notice of Appeal Rights

NOTICE OF APPEAL RIGHTS

You have a right to appeal any decision we make that denies payment on your claim or your request for coverage of a health care service or treatment.

You may request more explanation when your claim or request for coverage of a health care service or treatment is denied or the health care service or treatment you received was not fully covered. Contact [1] us when you:

- Do not understand the reason for the denial;
- Do not understand why the health care service or treatment was not fully covered;
- Do not understand why a request for coverage of a health care service or treatment was denied;
- Cannot find the applicable provision in your Benefit Plan Document;
- Want a copy (free of charge) of the guideline, criteria or clinical rationale that we used to make our decision; or
- Disagree with the denial or the amount not covered and you want to appeal.

If your claim was denied due to missing or incomplete information, you or your health care provider may resubmit the claim to us with the necessary information to complete the claim.[1]

Appeals: All appeals for claim denials (or any decision that does not cover expenses you believe should have been covered) must be sent to [insert address of where appeals should be sent to the health carrier] within **180 days** of the date you receive our denial.[2] We will provide a full and fair review of your claim by individuals associated with us, but who were not involved in making the initial denial of your claim. You may provide us with additional information that relates to your claim and you may request copies of information that we have that pertains to your claims. We will notify you of our decision in writing within **60 days** of receiving your appeal.[3] If you do not receive our decision within **60 days** of receiving your appeal[3], you may be entitled to file a request for external review.[4]

External Review[4]: We have denied your request for the provision of or payment for a health care service or course of treatment. You may have a right to have our decision reviewed by independent health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested by submitting a request for external review within **4 months** after receipt of this notice to the Office of the Insurance Commissioner [insert address and telephone number of the office of the insurance commissioner or other unit in the office that administers the external review program]. For standard external review, a decision will be made within **45 days** of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an **expedited external review** of our denial. If our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigation, you also may be entitled to file a request for external review of our denial. For details, please review your Benefit Plan Document, contact us or contact your state insurance department.[1]

[1] See address and telephone number on the enclosed Explanation of Benefits if you have questions about this notice.
[2] Unless your plan or any applicable state law allows you additional time.
[3] Some states and plans allow you more (or less) time to file an appeal and less (or more) time for our decision. See your Benefit Plan Document for your state's appeal process.
[4] See your Benefit Plan Document for your state's appeal process and to determine if you're eligible to request an external review in your state (e.g. some state appeal processes require you to complete your insurer's appeal process before filing an external review request unless waived by your insurer; while some states do not have such a requirement).

ALL NEW LANGUAGE

Appendix B – Model External Review Request Form

This **EXTERNAL REVIEW REQUEST FORM** must be filed with [insert state insurance department] within **FOUR (4) MONTHS** after receipt from your insurer of a denial of payment on a claim or request for coverage of a health care service or treatment.

EXTERNAL REVIEW REQUEST FORM

APPLICANT NAME _____ Covered person/Patient Provider Authorized Representative

COVERED PERSON/PATIENT INFORMATION

Covered Person Name: _____ Patient Name: _____

Address:_____

_____

Covered Person Phone #: Home (_____)_____ Work (_____)_____

INSURANCE INFORMATION

Insurer/HMO Name: _____

Covered Person Insurance ID#: _____

Insurance Claim/Reference #: _____

Insurer/HMO Mailing Address: _____

_____

Insurer Telephone #: (_____)_____

EMPLOYER INFORMATION

Employer's Name: _____

Employer's Phone #: (_____)_____

Is the health coverage you have through your employer a self-funded plan? _____. If you are not certain please check with your employer. Most self-funded plans are not eligible for external review. However, some self-funded plans may voluntarily provide external review, but may have different procedures. You should check with your employer.

HEALTH CARE PROVIDER INFORMATION

Treating Physician/Health Care Provider: _____

Address:_____

_____

_____

Contact Person: _____Phone: ( ) _____

Medical Record #:_____

REASON FOR HEALTH CARRIER DENIAL (Please check one)

The health care service or treatment is not medically necessary.

The health care service or treatment is experimental or investigational.

SUMMARY OF EXTERNAL REVIEW REQUEST (Enter a brief description of the claim, the request for health care service or treatment that was denied, and/or attach a copy of the denial from your health carrier)*

_____

_____

*You may also describe in your own words the health care service or treatment in dispute and why you are appealing this denial using the attached pages below.

EXPEDITED REVIEW

If you need a fast decision, you may request that your external appeal be handled on an expedited basis. To complete this request, your treating health care provider must fill out the attached form stating that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.

Is this a request for an expedited appeal? Yes _____ No _____

SIGNATURE AND RELEASE OF MEDICAL RECORDS

To appeal your health carrier's denial, you must sign and date this external review request form and consent to the release of medical records.

I, _____, hereby request an external appeal. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize by insurance company and my health care providers to release all relevant medical or treatment records to the independent review organization and the [insert state insurance department name]. I understand that the independent review organization and the [insert state insurance department name] will use this information to make a determination on my external appeal and that the information will be kept confidential and not be released to anyone else. This release is valid for one year.

_____ _____

Signature of Covered Person (or legal representative)* Date

*(Parent, Guardian, Conservator or Other – Please Specify)

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

(Fill out this section only if someone else will be representing you in this appeal.)

You can represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my appeal on my behalf.

_____ _____

Signature of Covered Person (or legal representative)* Date

*(Parent, Guardian, Conservator or Other—Please Specify)

Address of Authorized Representative: _____

_____

Phone #: Daytime (_____)_____ Evening (_____)_____

HEALTH CARE SERVICE OR TREATMENT DECISION IN DISPUTE

DESCRIBE IN YOUR OWN WORDS THE DISAGREEMENT WITH YOUR HEALTH CARRIER. INDICATE CLEARLY THE SERVICE(S) BEING DENIED AND THE SPECIFIC DATE(S) BEING DENIED. EXPLAIN WHY YOU DISAGREE. ATTACH ADDITIONAL PAGES IF NECESSARY AND INCLUDE AVAILABLE PERTINENT MEDICAL RECORDS, ANY INFORMATION YOU RECEIVED FROM YOUR HEALTH CARRIER CONCERNING THE DENIAL, ANY PERTINENT PEER LITERATURE OR CLINICAL STUDIES, AND ANY ADDITIONAL INFORMATION FROM YOUR PHYSICIAN/HEALTH CARE PROVIDER THAT YOU WANT THE INDEPENDENT REVIEW ORGANIZATION REVIEWER TO CONSIDER.

WHAT TO SEND AND WHERE TO SEND IT

PLEASE CHECK BELOW (NOTE: YOUR REQUEST WILL NOT BE ACCEPTED FOR FULL REVIEW UNLESS ALL FOUR (4) ITEMS BELOW ARE INCLUDED*)

1. **YES**, I have included this completed application form signed and dated.

2. **YES**, I have included a photocopy of my insurance identification card or other evidence showing that I am insured by the health insurance company named in this application;

3. **YES****, I have enclosed the letter from my health carrier or utilization review company that states:
   (a) Their decision is final and that I have exhausted all internal review procedures; or
   (b) They have waived the requirement to exhaust all of the health carrier's internal review procedures.

**You may make a request for external review without exhausting all internal review procedures under certain circumstances. You should contact the Office of the Insurance Commissioner [insert address and telephone number of the office of the insurance commissioner or other unit in the office that administers the external review program].

4. **YES**, I have included a copy of my certificate of coverage or my insurance policy benefit booklet, which lists the benefits under my health benefit plan.

*Call the Insurance Department at [insert appropriate telephone number(s)] if you need help in completing this application or if you do not have one or more of the above items and would like information on alternative ways to complete your request for external review.

If you are requesting a standard external review, send all paperwork to: [insert address where paperwork should be mailed].

If you are requesting an expedited external review, call the Insurance Department before sending your paperwork, and you will receive instructions on the quickest way to submit the application and supporting information.

CERTIFICATION OF TREATING HEALTH CARE PROVIDER
FOR EXPEDITED CONSIDERATION OF A PATIENT'S EXTERNAL REVIEW APPEAL

NOTE TO THE TREATING HEALTH CARE PROVIDER

Patients can request an external review when a health carrier has denied a health care service or course of treatment on the basis of a utilization review determination that the requested health care service or course of treatment does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested. The [insert name of state insurance department] oversees external appeals. The standard external review process can take up to 45 days from the date the patient's request for external review is received by our department. Expedited external review is available only if the patient's treating health care provider certifies that adherence to the time frame for the standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. An expedited external review must be completed at most within 72 hours. This form is for the purpose of providing the certification necessary to trigger expedited review.

GENERAL INFORMATION

Name of Treating Health Care Provider: _____

Mailing Address: _____

_____

Phone Number: (_____)_____ Fax Number: (_____)_____

Licensure and Area of Clinical Specialty: _____

_____

Name of Patient: _____

Patient's Insurer Member ID#: _____

CERTIFICATION

I hereby certify that: I am a treating health care provider for _____ (hereafter referred to as "the patient"); that adherence to the time frame for conducting a standard external review of the patient's appeal would, in my professional judgment, seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function; and that, for this reason, the patient's appeal of the denial by the patient's health carrier of the requested health care service or course of treatment should be processed on an expedited basis.

_____
Treating Health Care Provider's Name (Please Print)

_____ _____
Signature Date

PHYSICIAN CERTIFICATION
EXPERIMENTAL/INVESTIGATIONAL DENIALS
(To Be Completed by Treating Physician)

I hereby certify that I am the treating physician for _____ (covered person's name) and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the insurance company's determination that the proposed therapy is experimental and/or investigational. I understand that in order for the covered person to obtain the right to an external review of this denial, as treating physician I must certify that the covered person's medical condition meets certain requirements:

In my medical opinion as the Insured's treating physician, I hereby certify to the following:
(Please check all that apply) (**NOTE:** Requirements #1 - #3 below must all apply for the covered person to qualify for an external review).

1) The covered person has a terminal medical condition, life threatening condition, or a seriously debilitating condition.

2) The covered person has a condition that qualifies under one or more of the following:
[please indicate which description(s) apply]:

Standard health care services or treatments have not been effective in improving the covered person's condition;

Standard health care services or treatments are not medically appropriate for the covered person; or

There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the requested or recommended health care service or treatment.

3) The health care service or treatment I have recommended and which has been denied, in my medical opinion, is likely to be more beneficial to the covered person than any available standard health care services or treatments.

4) The health care service or treatment recommended would be significantly less effective if not promptly initiated.
Explain:_____

_____

5) It is my medical opinion based on scientifically valid studies using accepted protocols that the health care service or treatment requested by the covered person and which has been denied is likely to be more beneficial to the covered person than any available standard health care services or treatments.
Explain: _____

_____

6) Please provide a description of the recommended or requested health care service or treatment that is the subject of the denial. (Attach additional sheets as necessary)

_____

_____

_____ _____
Physician's Signature Date

ALL NEW LANGUAGE

Appendix C – Independent Review Organization External Review Annual Report Form

[Insert Name of State Insurance Department]

Independent Review Organization External Review Annual Report Form

External Review Annual Summary for 20 _____.

Due on [insert date] for previous calendar year.

Each independent review organization (IRO) shall submit an annual report with information for each health carrier in the aggregate on external reviews performed in [insert name of state] only.

1. IRO name: _____ Filing date: _____

2. IRO license/certification no: _____

3. IRO address: _____

   City, State, ZIP: _____

4. IRO Web site: _____

5. Name, email address, phone and fax number of the person completing this form:

   _____

   _____

6. Name and title of the person responsible for regulatory compliance and quality of external reviews:

   Name: _____ Title: _____

7. Total number of requests for external review received from [insert state insurance department name] during the reporting period: _____

8. Number of standard external reviews: _____

9. Average number of days IRO required to reach a final decision in standard reviews: _____

10. Number of expedited reviews completed to a final decision: _____

11. Average number of days IRO required to reach a final decision in expedited reviews: _____

12. Number of medical necessity reviews decided in favor of the health carrier: _____

    Briefly list procedures denied: _____

13. Number of medical necessity reviews decided in favor of the covered person: _____

    Briefly list procedures approved: _____

    _____

    _____

    _____

14. Number of experimental/investigational reviews decided in favor of the health carrier: _____

    Briefly list procedures denied: _____

    _____

    _____

    _____

15. Number of experimental/investigational reviews decided in favor of the covered person: _____

    Briefly list procedures approved: _____

    _____

    _____

    _____

16. Number of reviews terminated as the result of a reconsideration by the health carrier: _____

17. Number of reviews terminated by the covered person: _____

18. Number of reviews declined due to possible conflict with:

    Health carrier _____ Covered person _____ Health care provider _____

    Describe possible conflicts(s) of interest: _____

19. Number of reviews declined due to other reasons not reflected in #18 above: _____

ALL NEW LANGUAGE

Appendix D – Model Health Carrier External Review Annual Report Form

[Insert Name of State Insurance Department]

Health Carrier External Review Annual Report Form

External Review Annual Summary for 20 ____.

Due on [insert date] for previous calendar year.

Each health carrier shall submit an annual report with information in the aggregate by State and by type of health benefit plan.

1. Health carrier name: _____ Filing Date: _____

2. Health carrier address: _____

   City, State, ZIP: _____

3. Health carrier Web site: _____

4. Name, email address, phone and fax number of the person completing this form:

   _____

   _____

5. Total number of external review requests received from [insert state insurance department name] during the reporting period: _____

6. From the total number of external review requests provided in Question 5, the number of requests determined eligible for a full external review: _____

RESCISSION DATA CALL
of the NAIC Regulatory Framework (B) Task Force

December 2, 2009

DRAFT

Executive Summary

In October 2009, the Regulatory Framework (B) Task Force issued a data call to 52 companies that wrote individual major medical policies or individually underwritten certificates.

The data call was divided into four parts. The first part of the data call was designed to determine the actual numbers of policies/certificates that were written and in force and how many were rescinded in each state per year. In the second part of the data call, the Task Force requested information on the underlying conditions that were the basis of the rescissions. In the third part, the companies were asked to provide information on their underwriting and rescission-making process. Finally, each company was asked to provide details on their rescission appeal process, if one was in place.

The data call revealed that there were roughly 27,246 rescissions against a sampling size of about 6.7 million issued policies. This translates into a rescission rate of 3.7 rescissions for every 1,000 policies/certificates that were written over the five-year period covered by the survey (2004 to 2008). The rate of rescissions peaked in 2005 and was at its lowest in 2008. Psychiatric conditions were cited most frequently as the basis for a rescission. The rescissions and rescission rates were also summarized by state and by company. While it is not the intent of this report to isolate specific companies, three companies do have significantly higher rescission rates and account for the higher rescission rates in some of the states.

As would be expected, the companies reported having a robust information-gathering process for underwriting policies and when considering a rescission. Almost all of the companies also have detailed rescission appeal processes in place that include two or three tiers of appeal, including the use of third parties as well as medical and legal experts.

Overall, the rescission rate for the industry (based on this sampling) seems to present no issues on an industrywide scale. Because the majority of the individual major medical policies are medically underwritten, it is important for companies to have the right to rescind a policy if the information provided by an applicant is both fraudulently misrepresented, and material to the condition for which coverage is being sought. This serves not only to protect the company, but also to protect their customer base, whose premiums are based on the collective experience of the book of business. To guard against incorrect decisions to rescind, the companies included in this data call have attempted to implement appeal processes that include reviewers that are not associated with the original decisions to underwrite or rescind a policy and, in many cases, are not associated with the company.

After some background information, the remainder of this report will present the details of the findings in the order in which they were asked in the data call: (1) the number of policies/certificate issued and in force, as well as the number of rescissions; (2) the cited conditions that were that basis of the rescissions; (3) the information sources used for underwriting and rescinding a policy; and (4) the appeals processes of the companies.

Background

In a July 24, 2009, letter to Chairman Bart Stupak (D-MI) of the U.S. House of Representatives' Energy and Commerce Subcommittee on Oversight and Investigation, NAIC President Roger A. Sevigny (NH), Commissioner Sandy Praeger (KS), Commissioner Joel Ario (PA) and NAIC CEO Therese M. Vaughan, Ph.D., advised the House Committee that:

> …the NAIC Regulatory Framework (B) Task Force has been given the responsibility of determining to what extent rescissions are used and of recommending laws and regulations to prevent abuse of the [rescission] process. To this end, at its most recent meeting in June, the Task Force approved a data call that will be sent to insurers selling coverage in the non-group market. This data call is intended to uncover the number of policies that have been rescinded in each state over the past five years, the health conditions that are most frequently cited as the basis of rescissions, and determine the formal procedures the insurers have in place to review rescission decisions.

The referenced data call was sent to 52 companies that reported writing individual major medical polices. The policies issued by these 52 companies encompassed 80% of the lives covered by individual major medical policies. Three companies were eventually exempted from the data call because they either wrote only group and non-major medical insurance, or they wrote only governmental plans that were not vulnerable to rescissions at the insurer's discretion. In addition, the data call was sent to each company by the insurance department of the domiciliary state. One state decided not to participate, because its three companies had already responded to the previous, similar survey issued by U.S. Rep. Henry Waxman (D-CA) of the House Oversight Committee in October 2008. In total, responses were received from 46 companies (four additional responses were received from companies that were not originally part of the sample, but wrote individual major medical policies and were affiliated with other companies that were part of the original sampling) representing a sample of 70% of the covered lives and 69% of the premium earned in 2008.

To meet its charge, the Regulatory Framework (B) Task Force designed the data call (Appendix A) to address the five-year time span of 2004 through 2008. It asked each company for the total number of individual major medical policies issued and in-force by state for each year, as well as the total number of rescissions by state per year. In addition, the data call asked how many of the total rescissions were based on conditions that were undiagnosed prior to the application. Each company was also requested to provide the top four conditions upon which the rescissions were based and, if any rescissions were based on conditions undiagnosed prior to the application, the top four conditions for those rescissions.

The data call defined an individual major medical policy as "…a type of health insurance policy designed to cover an individual, or an individual and specified dependents, for hospital, medical and surgical expenses." It specifically did not include "…among other things: standalone dental or vision plans, specified/named disease policies, short-term health insurance policies (of less than 12 months in total duration), hospital indemnity insurance policies, long-term care insurance policies, supplemental insurance policies, or disability income policies." The companies that received a data call were asked to not include any governmental plan information with their data if the policies were not vulnerable to rescission at the company's discretion.

Along with the actual numbers of policies and rescissions, the data call asked the companies what information was used in underwriting a policy and what information was used in making a decision to rescind a policy. Finally, the data call asked the companies to explain what procedures were in place to allow a consumer to appeal a determination to rescind a policy.

In order to fulfill the responsibility of the Task Force, this report aggregates the data received, totals the rescissions nationally and by state, and summarizes the responses received regarding underwriting, rescission and appeal procedures.

The Sample Size of Individual Major Medical Policies and Certificates

In the five-year period, 2004 to 2008, the 46 companies issued more than 6.7 million individual major medical policies. The number of policies issued in each year rose consistently. Over the five-year period, there was a 50% increase in the number of such policies issued (Figure 1). The number of in-force policies also increased about 50% during the same period, totaling almost 4 million policies in-force by the end of 2008 (Figure 2).

Figure 1

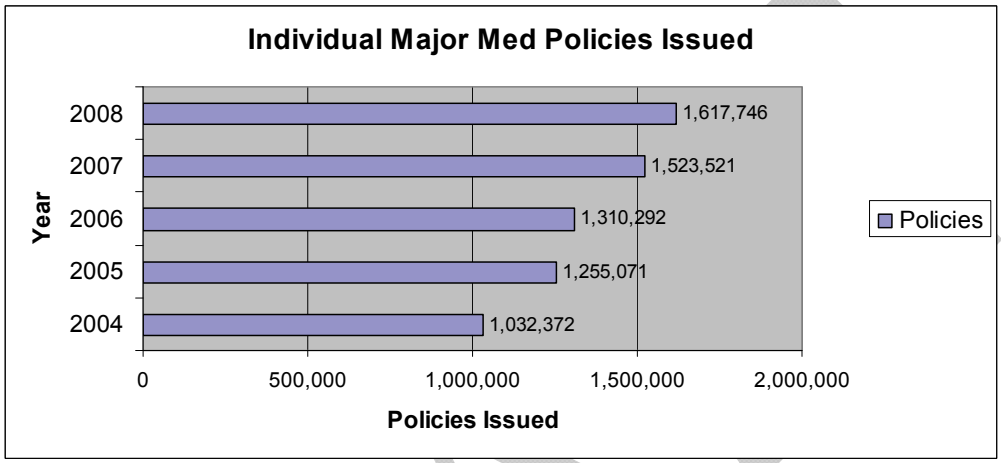
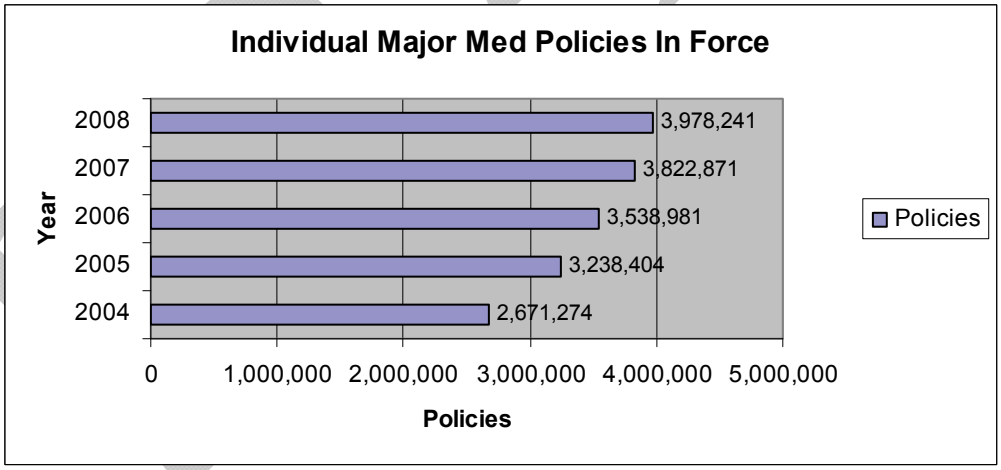


Figure 2



Per the counts reported by the insurers in the data call, about 8% of the individually underwritten major medical coverage is written on a certificate basis. The number of such certificates written per year is illustrated in Figure 3. The in-force number of certificates is provided in Figure 4. Interestingly, in 2006, the sampled insurers reported having individually underwritten an additional 7,200 certificates, yet reported that the in-force number of certificates dropped at year-end 2006 by 3,700 certificates.

Figure 3

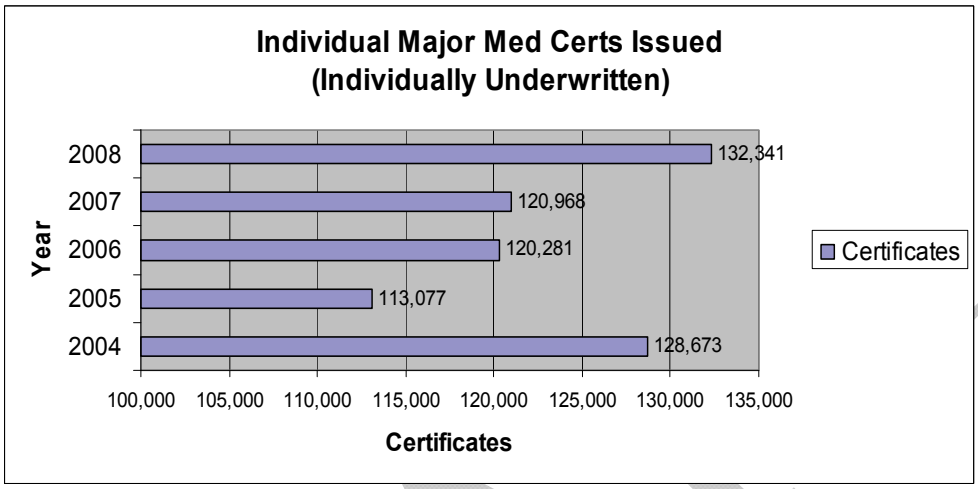
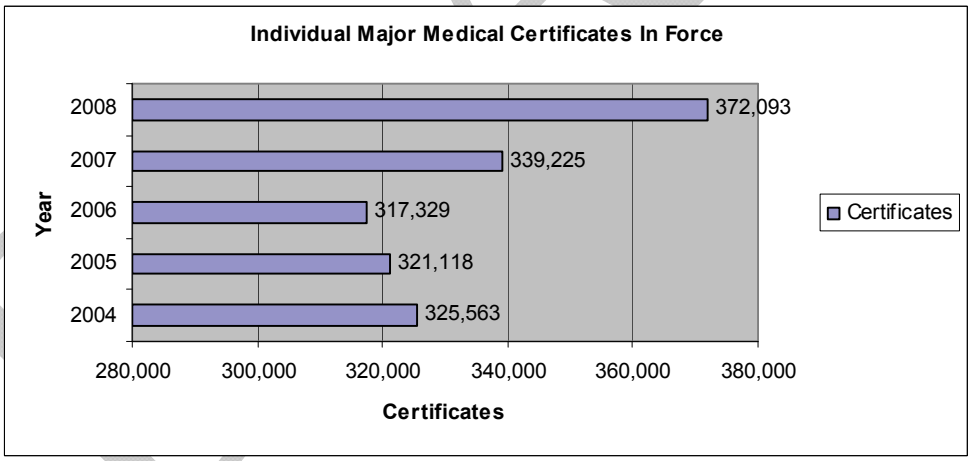


Figure 4



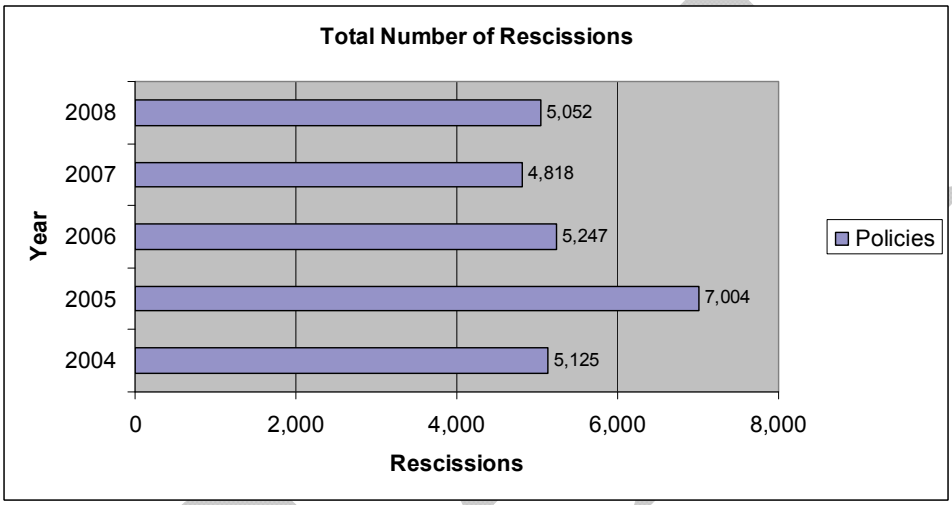
Adding together all of the policies and certificates written per year for the companies responding to the data call, there were 7.35 million individually underwritten polices and certificates issued in the five-year period sampled. At the end of 2008, there were a total of 4.35 million policies and certificates in-force.

Rescissions

In the data call, the Task Force asked for the total number of policies and certificates rescinded in each year for each state. Although the number of certificates was counted, there was no distinction made whether a rescinded insured was a policyholder or a certificateholder. Please note that some companies rescinded coverage for individuals and not the entire policy. A rescission, therefore, does not necessarily indicate the rescission of an entire policy or certificate.

Figure 5 shows the total number of rescissions nationally by year and for the entire five-year period of the data call. The figure shows that there was a 27% increase in the raw number of rescissions from 2004 to 2005. After 2005, the number of rescissions begins to decline to a low of 4,818 in 2007. There was a 5% increase in the number of rescissions in 2008.

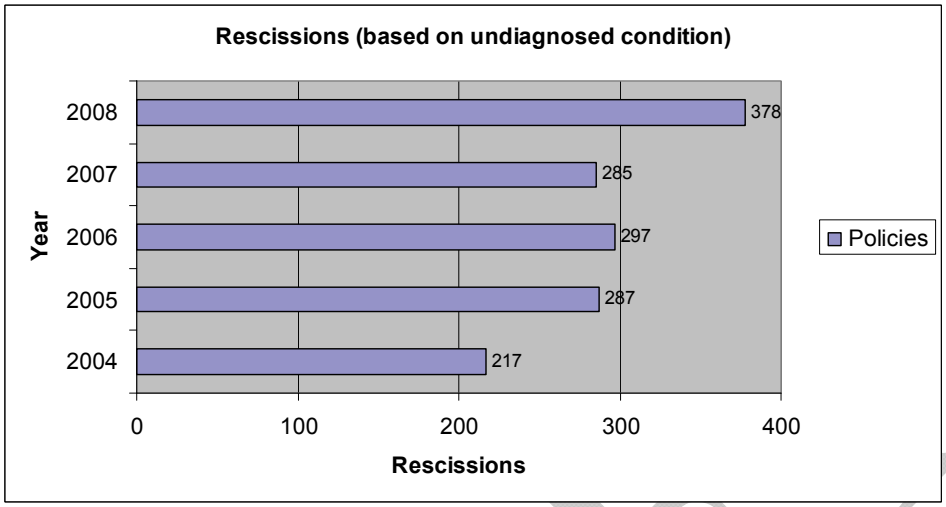
Figure 5



The data call asked each company for "the total number of policies and certificates rescinded in the calendar year" (the source of the data for Figure 5). It also asked for "the number of policies and certificates rescinded in the calendar year, based on a condition(s) not diagnosed prior to application". The second data element was included to encompass those situations in which an applicant has received indications of a medical condition, but has postponed any testing to confirm a diagnosis until after an application has been completed and a policy or certificate has been issued.

The number of rescissions based on condition(s) undiagnosed prior to the application was about 5% of the total number of rescissions. The actual number of these rescissions is illustrated in Figure 6. Unlike the total number of rescissions, these rescissions peaked in 2008 (instead of 2006), contributing to 7% of the total rescissions for that year. Except for a decrease from 2006 to 2007, the number of rescissions based on conditions undiagnosed prior to the application has increased each year.

Figure 6



Using the above data, rescission ratios could be calculated per the number of polices/certificates issued and per the number of policies/certificates in-force for each year (Figure 7).

Figure 7

The ratios were derived per every 1,000 policies and certificates. These ratios used the total number of rescissions and we did not calculate a separate ratio for rescissions based on conditions that were undiagnosed prior to the application because they were such a small percentage of the total.

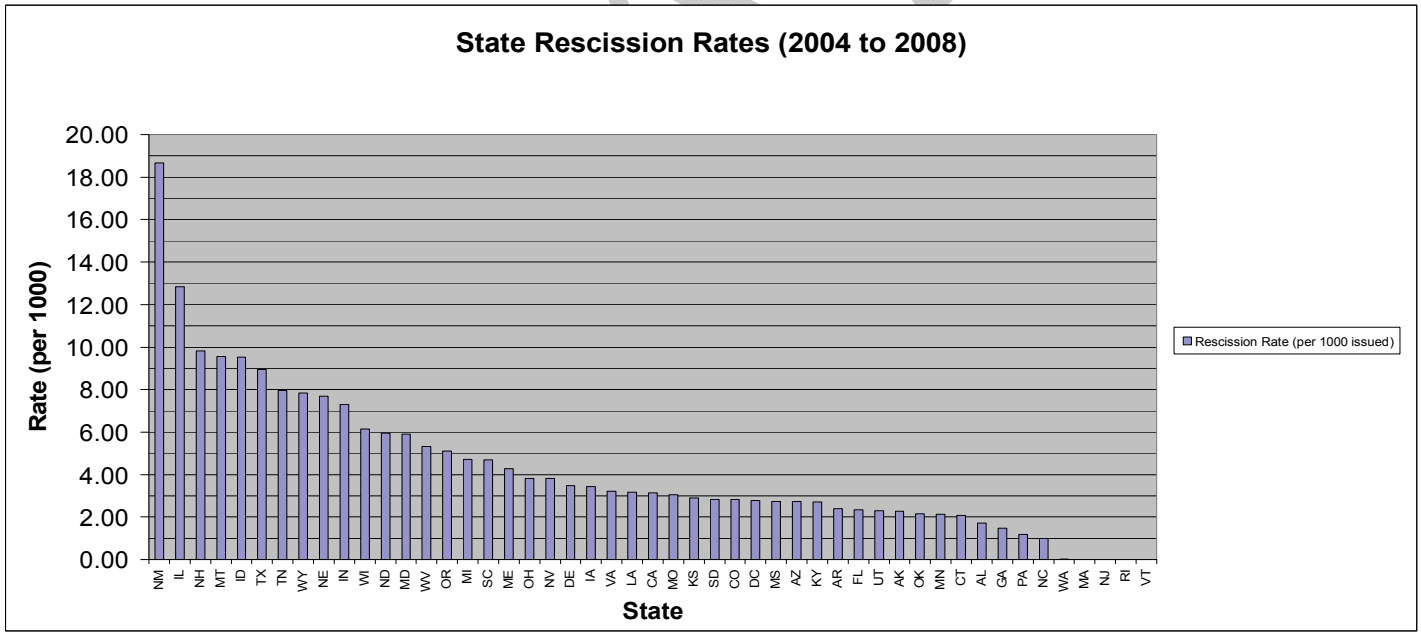
The peak rescission rate occurred in 2005, with approximately five of every 1,000 issued policies being rescinded. Because rescissions might also occur on policies that were issued in prior years, it is helpful to also look at the number of rescissions compared to the number of policies in-force at the end of each year. Again, the rescission ratio peaked in 2005, with approximately 2 of every 1,000 in-force policies being rescinded. After 2005, there was a steep decline in the rescission rate, decreasing just more than 40% to 2.9 rescissions for every 1,000 policies issued and 1.2 rescissions for every 1,000 policies in-force.

For the five-year period of the data call, the rescission ratio is 3.7 rescissions per 1,000 policies issued. Excluding the first two years of 2004 and 2005, the rescission ratio is about 3.1 rescissions per 1,000 policies issued.

In 2005, the California Department of Managed Health Care began its investigation into the rescission practices of some of the health insurers in its state. Fines were announced in 2007 and a settlement was reached in 2009. The reduction in the numbers of rescissions and the rescission rates appear to have begun in 2006 and reached their minimum in 2007 and 2008. Though there is not enough data from enough insurers to draw any firm conclusions, there does seem to be some connection with the actions of the State of California regarding rescissions.

One of the responsibilities of the Regulatory Framework (B) Task Force was to determine the number of rescissions per state. The rescission ratios per state are provided in Figure 8.

Figure 8



Because so few companies write in any individual state, the sample size for each state is a fraction of the national sampling. This explains the wide swing in rescission ratios from 18.5 per 1000 policies issued to as little as none or 1 per 1000 issued. Two states, Hawaii and New York, did not have any companies reporting individual major medical business. New Jersey and Rhode Island each had a small amount of business reported and no rescissions. In Maine, Massachusetts, New Jersey, New York, Washington and Vermont health insurers are required to provide health coverage on a guaranteed-issue basis with no medical underwriting.

To provide some perspective to the ratios in Figure 8, the raw numbers reported by the sampled companies for each state are provided in Table 1. All columns are five-year totals reported in each state.

Table 1

State	Total Issued	Total In Force	Total Rescissions	Rescissions - condition(s) not diagnosed	State	Total Issued	Total In Force	Total Rescissions	Rescissions - condition(s) not diagnosed
AK	2,205	3,853	5	0	MT	10,580	39,440	101	0
AL	91,083	275,113	157	1	NC	339,933	1,079,351	337	3
AR	76,942	287,255	184	1	ND	4,536	15,309	27	0
AZ	224,683	636,688	613	11	NE	26,556	65,061	204	10
CA	1,192,463	2,462,211	3,736	213	NH	3,770	10,147	37	0
CO	183,220	433,032	519	22	NJ	0	38	0	0
CT	89,305	194,470	186	9	NM	35,065	119,101	655	52
DC	16,143	37,883	45	1	NV	56,898	136,196	217	4
DE	3,728	6,336	13	1	OH	205,484	523,344	785	42
FL	630,997	1,447,418	1,480	76	OK	78,922	81,259	169	3
GA	346,202	912,789	514	23	OR	91,136	277,997	465	0
IA	95,276	397,767	328	1	PA	295,238	745,854	350	88
ID	5,564	14,393	53	0	RI	246	247	0	0
IL	410,877	1,122,140	5,279	353	SC	92,838	260,394	436	7
IN	35,324	70,459	258	6	SD	27,848	120,321	79	1
KS	94,151	326,317	274	5	TN	43,174	79,434	343	7
KY	141,590	480,591	383	25	TX	378,705	960,040	3,389	212
LA	148,950	508,120	471	55	UT	58,086	155,197	134	6
MA	273,649	238,237	0	0	VA	293,498	779,038	942	95
MD	163,392	443,407	966	5	VT	0	12	0	0
ME	466	457	2	0	WA	250,102	630,826	9	0
MI	323,040	628,299	1,520	81	WI	42,913	101,948	264	4
MN	139,246	911,380	295	0	WV	4,504	9,249	24	0
MO	250,933	585,289	762	39	WY	6,120	13,423	48	0
MS	68,761	297,969	188	2					

Rescissions within the Contestability Period

All of the companies were asked to identify how many rescissions were made within the contestability period established by the state where the policy or certificate was issued. From 2004 through 2008, there were 1,464 policies/certificates that were rescinded based on a condition that was undiagnosed prior to the application. For all such reported rescissions (except for three times), the same number of rescissions were reported as having been made within the contestability period; i.e., 1,461.

Health Conditions Most Frequently Cited as a Cause for Rescission

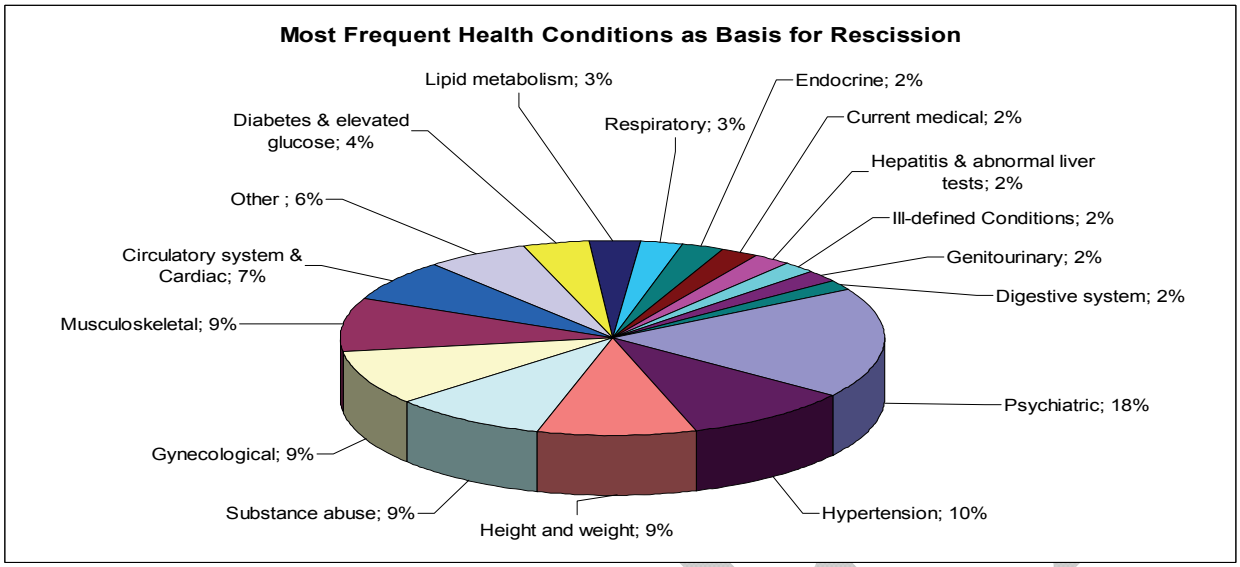
In addition to the actual numbers of rescissions within each state, the data call asked the companies to identify the top four conditions that were most frequently cited as the reason for a rescission in the five-year period. The top four conditions were to be provided for the total rescissions, as well as rescissions that were based on conditions that were undiagnosed at the time of the application.

Many companies responded correctly by providing one list of conditions that covered the five-year span of years. Quite of few others, however, provided the information on a yearly basis, and cited the top four conditions in each year and in each state. To compensate for this mix in method of reporting, we tracked the most frequent conditions per year. If a company reported only one list for the entire five-year period, each condition was counted once in each year. Once all the responses were tallied per year, they were totaled for the entire five-year period. Although the individual yearly totals might be misrepresented by the companies that reported just one list of conditions, the cumulative total for the five years should be reflective of the sample as a whole.

Different companies reported the same conditions using different terminology. We aggregated the responses in the most comprehensive categories. For example, drug abuse, substance abuse, alcohol abuse and smoking were often either mentioned separately or together. We put them into one category labeled "substance abuse." Anxiety, depression and mental disorders were all combined in the "psychiatric" category. There might be some disagreement as to which category a condition belongs. For example, it was not clear whether arthritic conditions belong in the "musculoskeletal" category. We attempted to keep the most frequently cited categories as the main categories. Any condition that was cited fewer than three times in any one year was categorized under "other." A full list, which breaks out the "other" category for each year, is provided in Appendix B.

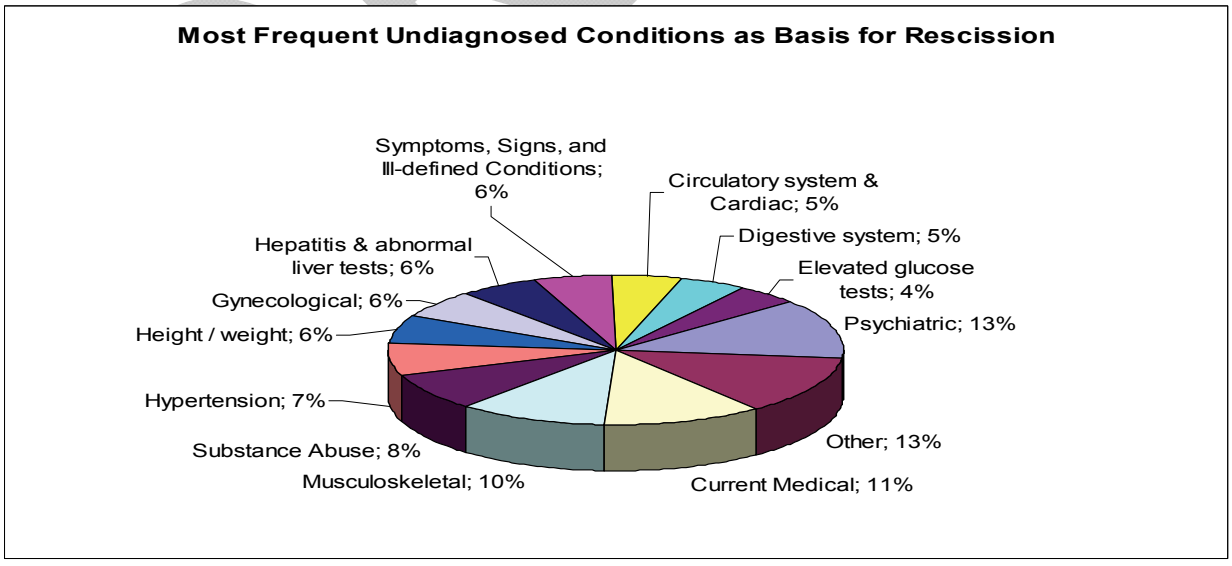
Figure 9 is a pie chart of the most frequently cited conditions for all rescissions reported by the companies. Of all the rescissions, 48% of them fell into one of the four broad categories of psychiatric (18%); hypertension (10%); height and weight, including obesity (9%); and substance abuse (9%).

Figure 9



For rescissions based on conditions that were undiagnosed prior to an application being completed, Figure 10 illustrates the most frequently cited conditions that were the basis of such rescissions. This survey data element combined rescissions and company decisions to apply a pre-existing condition exclusion. The top four categories accounted for 47% of the rescissions. Again, psychiatric conditions (13%) were the most frequently cited basis. Many specific conditions were the basis of another 13% of these rescissions and are classified as "other." No one condition in this category was cited often enough to fall into its own named category. A more comprehensive list of what fell into the "other" category is provided in Appendix B; it includes such conditions as sleep apnea, hypercholesterolemia and headaches. Current medical testing due to be completed, follow-up appointments that have not yet been completed, and current prescriptions are all included in "current medical," which accounts for 11% of the rescissions. Musculoskeletal conditions are the basis for another 10% of the rescissions or the application of a pre-existing condition exclusion.

Figure 10



Types of Information Used in Underwriting a Policy

The companies were asked to provide, in an attachment, the types of information used in underwriting a policy. Every company, except the two Massachusetts health carriers, cited an enrollment application as the primary source of underwriting information. As noted above, Massachusetts health carriers must guarantee issuance and cannot medically underwrite.

Most of the applications included medical release forms that the applicant is required to sign. In addition to the application, medical records and prescription drug history, most companies relied on additional written and verbal communication with the applicant, as well as any prior claim history or prior applications that the company had for an applicant. Table 2 lists all the responses for this data call question.

Table 2

Sources of Underwriting Information	Responses
Application	44
Medical Records	34
Additional verbal or written information	19
Prior claims	16
Prescription drug history	15
Prior applications	11
Paramedical exams, including lab tests	7
State motor vehicle records	1
Visa (for non-US citizens)	1
Replacement form (if applicable)	1

Types of Information Used in a Rescission Determination

The companies utilized more sources of information when determining whether to rescind a policy. The leading source was, of course, the medical records of the insured that was compared to the information gathered at the time of underwriting. As in underwriting a policy, the prior claims and application history can also be reviewed. Often, the insured is asked to provide verbal or written comments regarding the information gathered by the insurer or provided by the insured at the time of the application. Table 3 lists all of the sources of information cited by the companies.

Table 3

Sources of Information Considered for a Rescission	Responses
Medical records	33
Additional verbal or written information	19
Comparison with data gathered at underwriting	17
Claims history	17
Prescription drug history	15
Prior applications	10
Customer communication	3
Height and weight	3
Psychiatric records	2
Agent input	2
Underwriting policies and procedures	2
Effective date of coverage	1
Milliman Health Cost Guidelines	1
Referral diagnosis	1
Other pertinent documents	1
Underwriting and legal opinions	1

Rescission Appeal Process

All but three of the companies reported having an appeal process in place for policyholders to appeal a decision to rescind a policy. Seven companies did not respond to this question because they either did not or could not rescind a policy or certificate of coverage. All of these appeal processes included an initial internal review of the rescission. An internal review was most often conducted by officers or management that were not involved in the original decision. Frequently, the companies brought in legal and medical experts to assist in the review process. A second and third level of appeal was included in the appeal process of 17 of the companies. Usually, the second level of appeal was to an independent third party, and, in one instance, to an external utilization review agency. Many of the companies forwarded detailed appeal process policies and procedures. Table 4 summarizes the responses.

Table 4

Rescission Appeal Process	Responses
Internal committee, then third-party review	13
Internal committee	11
RN/MD/Legal – two levels of review	3
Rescission committee	2
Appeal rights consistent with state law	1
RN review	1
Special services (internal)	1
State Department of Insurance	1
Internal committee and/or third-party review	1
Internal / external utilization review agency / third-party review	1

W:\Dec09\TF\RF\RFTF Draft Rescission Data Call Report 12-02-09.doc