

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will not be considered medically underwritten and must, in each case, be subject to prior approval before it can be rescinded, cancelled or limited;
- Clarifying that no other policy can be rescinded, cancelled or limited for any reason without approval from the Insurance Commissioner unless the insurer or health center can prove first, through a submission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;

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- 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:

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