



6531

**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.



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.

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
Healthcare Advocate

Attachment:  case

State of Connecticut



THOMAS R. SULLIVAN
INSURANCE COMMISSIONER

P. O. BOX 816
HARTFORD, CT 06142-0816

Hartford

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 Ms. [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

1



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."

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. *Alvarado 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,

A handwritten signature in black ink, appearing to read "K. Lembo". The signature is fluid and cursive, with a long horizontal stroke at the end.

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 Name and Birth Date]

Male Female Sex

RESIDENT ADDRESS

[Redacted Address]

1. Are any of your dependents to be covered under the policy/certificate? Yes No

Table with 6 columns: Dependent's First Name, Relationship to You, Date of Birth, Dependent's First Name, Relationship to You, Date of Birth. Includes handwritten 'Spouse' and 'N/A'.

*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... an expectant mother or father?
3. Have you or anyone named above been declined for insurance due to health reasons?
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?
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?
6. Within the last 5 years, have you or anyone listed on the application received medical or surgical consultation, advice, or treatment...

DEDUCTIBLE: \$250 \$500 \$1,000 \$1,500 \$2,500 REQUESTED EFFECTIVE DATE: 10/30/07

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.

Proposed Insured's Signature of Parent/Legal Guardian if proposed insured is a child
State where you signed this application
Date you signed and read application
Licensed Agent or Broker (Please Print)
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.

**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:** [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 misrepresentation and may be the basis for later rescission of my coverage and that of my dependents. In the event of rescission 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.

- Will there be any other health insurance in force on the policy date?
NO
- Is the proposed insured, spouse, or any dependent child now pregnant?
NO
- 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
- Is any proposed insured currently eligible for Medicaid?
NO
- Are you or any person proposed for coverage over 300 pounds if male or over 250 pounds if female?
NO
- 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 arthritis, degenerative joint disease of the knees or hips, alcohol abuse or chemical dependency, hemophilia?
NO
- 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 developed symptoms of the disease AIDS.
NO
- 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 prior 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 the group 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 acting 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 application 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) All information 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

Kevin
Dear Mr. Lembo:

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 Congress¹, 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

Mr. Kevin Lembo
September 4, 2008
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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

Handwritten notes:
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to the law
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