Health Insurance Rescissions and What They Tell Us About Needed Reforms

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One of the key areas of health reform being discussed as part of the presidential campaigns is health insurance. Everyone with coverage has a story of how an insurance company has denied coverage for needed services, delayed payment, or otherwise put red tape in front of a claim.

These types of issues have been in the forefront in the media the last few months as stories of rescissions have become front page news. Rescissions are cancellations of health insurance policies based on a misstatement of fact on the insured’s application for coverage.

Health Net, an insurance company based on California, was the first to feel the wave of public attention hit. At issue was Health Net’s policy of setting targets and rewarding for exceeded targets in its rescission department. Between 2000 and 2006, Health Net rescinded 1,600 policies resulting in over $35 million in avoided claims. The company’s senior analyst in charge of rescissions reviews exceeded the company’s goal of 15 cancellations a month; she averaged 22.9 rescinded policies. Health Net argued that bonuses were based on performance not on the goals alone, but public opinion had already turned against them when the facts of one of the rescissions made the news – a woman who had contracted breast cancer had her policy rescinded after the company found misstatements on her application about her weight and a heart condition. The woman argued that she had given all the information to an agent who wrote down her medical history. Whatever really happened, when the woman’s application was submitted, the public blamed the insurance company.

California insurers remained in the spotlight. Health Net was fined $1 million for failure to cooperate with state investigators. With presidential candidates focusing on potentially increasing the individual insurance market, the business practices of insurers took on an even greater meaning. California investigators began looking into the rescission policies of other big insurers in the state to check compliance with a state law prohibiting bonuses related to limiting claims. In addition to Health Net, fines were paid by WellPoint and Kaiser. Consumer advocates argued that rescissions should be limited to material misstatements as people are unlikely to remember every doctor’s visit, every prescription, and every diagnosis ever given when filling out applications.

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The news cooled off a bit over the holiday season, but it came back in force in February. The Los Angeles City Attorney filed suit against Health Net for inappropriate denial of claims and began looking into criminal charges relating to the bonuses tied to rescissions. Reports were published about Blue Cross of California’s attempt to enlist help from physicians in reporting to the insurer information not listed on the patient’s application. Physician resisted tattling on their patients, and public opinion caused Blue Cross to stop the practice, but the news was already out. As in the Health Net case, those involved in the Blue Cross scandal were individual, not group, policies.3

The insurance companies realized they had a public relations nightmare on their hands, a situation that was particularly hazardous during a highly contested campaign season in which presidential candidates were all making promises of reform. An industry group known as America’s Health Insurance Plans proposed its own solution to the problem – an independent review panel. Independent review panels had helped minimize issues with denied claims, and America’s Health Insurance Plans believed they could have the same impact on rescissions. A binding panel would review all proposed rescissions before they could be implemented. Prior to the announcement of the proposed plan, the Connecticut Attorney General’s Office began an investigation into coverage denials and an arbitration judge in California awarded $9.4 million to the woman with breast cancer whose coverage was canceled by Health Net.4

While the public was arguing that insurance companies were acting inappropriately and maybe private insurance companies needed to be cut out of health reform measures, the insurance companies were arguing that they were follow a solid business model and ensuring the viability of policies were no misstatements were made. The draft bill to create independent review panels from America’s Health Insurance Plans was suggested as a strong compromise given that patients prevailed before claims denial panels almost 50 percent of the time, and the National Association of Insurance Commissioners put the plan on its agenda for a March meeting.5 Many details about the plan remained either undisclosed or undetermined, but consumer advocates responded positively to the idea.6

An unlikely defender came to the insurance companies’ aid. Ezra Klein wrote an opinion piece published in the Los Angeles Times arguing that insurance companies were being attacked for acting as rational businesses should. Klein argued that the problem was not the companies but the marketplace itself. He noted that health insurance is not true insurance but a form of risk pooling to help offset costs and insurance companies are in

5 Id.
the business of making profits not providing care/coverage. Klein proposes changing the system to reward insurers for providing better care rather than forcing them to compete on denial of claims. His new market would require universality, an end to cherry-picking, risk adjustment – having insurers with healthy pools pay into a fund to reimburse those with sicker insureds, benefit floors, and information transparency.⁷

As with all of Klein’s writings in this area, his opinion is well thought out, well argued, and completely designed to support his own version of socialized insurance. His argument basically says that the insurance companies are profit-motivated because that is how we have set up the current system and what we demand of them. While that is one way to see the situation, it is not a terribly realistic one. His argument reflects some of the current health reform measures that focus on universal coverage with no pre-existing condition exclusions, no higher premiums for those with more claims, and relatively high levels of coverage. What is so amazing about most of these reform plans is that they are allegedly going to be implemented without raising taxes on the vast majority of US citizens. While it sounds like a wonderful plan, it is about as realistic as suggestions that the Massachusetts reform plan be implemented in Texas, ignoring the difference between a small state with six percent uninsured and a large one with 24-25 percent uninsured.

If we are truly going to reform the insurance market, we need to look at what it really is and the purposes that it truly serves. As Klein suggests, health insurance is more a risk pooling system. Catastrophic coverage meets the more traditional insurance model, but coverage for more regular care does not. Our current system relies on incredibly complicated contracts, and the insurance companies rescinding policies are acting entirely appropriately under contract law. The current system also fails to address the differing natures between catastrophic care and routine care.

Universal coverage for catastrophic care will help reduce medical bankruptcies without in turn bankrupting the companies covering those policies. Premiums could be based on geography, age, and gender and how those factors impact the risks of being a trauma victim. Rescissions would not be an issue. Patients would need to report changes in geography to their insurer, but there would be no need for long medical histories or investigations into statements made on applications. The application would consist of a driver’s license or similar identification showing the name, age, gender, and address of the person applying for coverage. It would be an easy, straightforward system, and one that would likely be supported by the hospitals and trauma specialists who find themselves covering a high number of charity cases.

Unless or until US citizens are willing to pay significantly higher taxes, coverage for routine care will not be viable without differences in premiums involving more detailed factors. Basic coverage has to be applied in a more discriminatory manner. A person with several chronic conditions will have to pay more into a risk pooling system than someone with an utterly clean bill of health. Having a person’s medical history

application completed in conjunction with a visit to their primary care doctor would reduce misstatements and the need for rescissions. Otherwise, people will still have coverage denied based on information in their contracts, and health insurance companies will continue to have a bad reputation for doing their job.

If we really want to achieve Medicare for all – and I have doubts that people touting this plan realize how underinsured most Medicare recipients really are – it will cost money, a lot of it. Eliminating tax breaks for the wealthy, reviewing estate taxes, and focusing on personal responsibility will all help cover a minor percentage of the bill. There is no magic bullet that will insure us all and cost us nothing. This is not the fault of the insurance companies or even the more popular bad guy pharmaceutical companies; it is a consequence of a growing and aging population and our ability to keep people alive longer with more complicated health conditions. If we want fertility treatments, organ donations, stem cell research, and other technologies used to keep us alive as long as possible, we will have to pay. Insurance companies need to play by the rules, but so do individuals seeking insurance. That should not be lost in our desire to find a simple solution to a complicated problem.