

USA Today
January 29, 2007
Julie Appleby

PEOPLE LEFT HOLDING BAG WHEN POLICIES REVOKED

Denise Wheeler, an artist in Laguna Beach, Calif., thought she and her family had health insurance. So did Tony Seals, a self-employed businessman in nearby Riverside. Across the country in Connecticut, Maria Locker and Linda Gaskill each bought short-term insurance policies to protect themselves against catastrophic costs.

But each was left with tens of thousands in unpaid medical bills when their insurers — all major companies — retroactively canceled their policies after they faced expensive health problems. "It's the most devastating thing that's ever happened to us," says Seals, 43.

Their stories illustrate a little-recognized fact about insurance purchased by individuals: Even after being approved, policyholders can see their coverage amended to exclude certain medical conditions or revoked entirely, sometimes long after the policies are issued.

"Insurers love to market the promise, 'We'll take care of you. Just sign here,' " says Karen Pollitz of the Institute for Health Care Research and Policy at Georgetown University. "Then there is all this opportunity for the insurer not to keep the promise, and you don't find out until it's too late."

Insurers say they rarely revoke policies, and generally do so only because of misleading or omitted information on applications. One large insurer, Blue Cross of California, says it revokes less than one-half of 1% of all individual policies each year. Requiring complete medical details and honesty on the part of applicants, insurers say, is necessary to control costs and weed out fraud.

"Our objective as an industry is to provide as affordable a product as possible," says Mohit Ghose of America's Health Insurance Plans, the industry association. "We have to rely on the medical record information supplied by the applicant."

Concern may grow as more people join the individual market, which now includes more than 16 million people nationwide. People buy individual policies because their employer doesn't offer health insurance — as is the case with about 39% of all employers; or because they retire before Medicare eligibility; or because they are self-employed, between jobs or jobless.

In California and Connecticut, high-profile disputes about after-the-fact cancellations are ongoing. The disputes come amid renewed interest in the uninsured in Washington, D.C., and in many states, as politicians from governors to President Bush call for ways to make it financially easier for people to buy insurance on the individual market.

'Gaming' the system?

But the individual market has hurdles that are not just financial: Insurers in most states can pick and choose whom to cover, often turning down those with medical problems in a process called underwriting. Even if they don't thoroughly check medical records before issuing a policy, insurers can "look back," sometimes for a decade or more, at a policyholder's records to check facts on the application.

Critics of the industry say the practice is overused.

"The newest tool insurers have found is to check into every sick person who files an expensive claim to see if there's an argument that they lied on their enrollment application," says Jamie Court of the Los Angeles-based advocacy group Foundation for Taxpayer & Consumer Rights.

Nationwide, data collected by the federal Agency for Health Care Research and Policy show that about 1% of people in the individual market have claims that total more than \$30,000 in a given year.

More than 200 complaints about revocations — 189 of them since 2003 — have been filed with California's Department of Managed Health Care, which holds a public hearing today to consider new regulations. Dozens of lawsuits have been filed against insurers by patients; some have been settled. Organizations representing California's doctors and hospitals have each asked to join a class-action suit against the insurers. And two of the state's largest health plans, Kaiser Permanente and Blue Cross of California, have been hit with six-figure fines for revoking policies.

Connecticut Attorney General Richard Blumenthal has asked the state's insurance commissioner to audit Assurant Health and consider "levying significant penalties" if it finds the insurer wrongfully revoked policies. And he has proposed legislation that would require all insurers to prove applicants had intentionally lied about their health before their policies could be revoked.

"The insurance companies are gaming and manipulating the system," Blumenthal says. "The effective way to protect individuals is to change the law."

Emergency surgery

Wheeler, 48, and her husband, Stephen, completed their application with the help of an insurance broker, seeking a policy for themselves and their three children. Stephen had left a corporate job that had insurance to start his own business. Court documents from a lawsuit the Wheelers filed Jan. 12 against their former insurer, Nationwide, show the policy was approved and went into effect on Dec. 1, 2005. Wheeler says the family paid \$700 a month in premiums.

In May 2006, Wheeler was rushed to the hospital with a perforated ulcer. Wheeler says she was unaware of the ulcer until she collapsed after her youngest son's baseball game. "You get this hole in your stomach that erupts," she says. "Your body fills up with toxins, and it kills you."

Not long after the five-hour surgery, Wheeler got a letter from her insurer asking for more information about her health history. On her application, she had not told the insurer that she went to an emergency room and her OB/GYN three months before applying for her insurance policy in October 2005, court documents say.

The visits were for heavy menstrual periods, not her stomach, court documents say. Wheeler told the insurer that her doctor had said everything was normal for a woman of her age.

Her insurer, citing the omission of information about the doctor visits, rescinded her policy, leaving the family owing about \$30,000 for her surgery. The insurers' letter said it would not have insured her had it known about the OB/GYN visits.

"What does this have to do with my stomach?" asks Wheeler, who remains uninsured.

A Nationwide spokesman said Thursday that the insurer had not yet been served with the lawsuit and therefore could not comment on the Wheeler case.

Policy canceled

Like the Wheelers, the Seals family bought coverage on the individual market after Tony Seals became self-employed. They applied online for an individual policy with Health Net on March 15, 2003. At the time, they had four children.

Seals answered all the questions, including one asking when his wife, Susan, had her last menstrual period. Insurers ask that question because most will not grant a policy to someone who is pregnant. The policy was approved and became effective April 1, 2003, according to court documents.

About mid-April, Seals says, they found out his wife was pregnant. The insurer approved all the prenatal visits and tests, he says. On Oct. 3, 2003, Susan Seals gave birth to their fifth child, Madeline, who has severe brain damage. "They had quite a bit of distress in delivery," Seals says. Their full-term baby had to be revived after birth. His wife spent almost three weeks in the hospital; his daughter, eight.

In April 2004, when Madeline was 6 months old, the insurer told them it had reviewed their application and "felt like we had not given them a correct date for my wife's last menstrual period, so would rescind the coverage," Seals says.

The insurer had looked at Seals' wife's OB/GYN records and found that she had told the doctor a date for her last period about two weeks' different than the one Seals had included on the application, Seals says.

Health Net spokesman Brad Kieffer said the insurer is "sorry to hear of the unfortunate situation the family is going through," but said it must rely on the information given in the insurance application.

"If we suspect misrepresentations have been made ... state laws and regulations permit us to investigate to get the facts," Kieffer said. "If we determine that misrepresentation has occurred, the policy is rescinded. It is the responsibility of the applicant to be sure all information on an application is correct and complete."

The cancellation left the family with about \$140,000 in unpaid bills from doctors, hospitals and other medical providers. Because the Sealses had brought a successful malpractice case stemming from his daughter's birth, they had money to pay \$95,000 toward those bills, leaving them with \$1 million in a trust fund that is to provide care for their daughter.

Madeline has severe cerebral palsy, is blind, can't roll over and will need care for the rest of her life, Seals said.

His wife has gone back to work, and her job provides the family with health insurance.

Short-term policies

In Connecticut, concern has centered on short-term health insurance policies, although Blumenthal says his office has also seen problems with longer-term policies.

Gaskill, a 63-year-old retiree, says she began buying policies from Assurant Health in 2005. After a six-month policy expired, she signed up for a new one with Assurant.

Her new policy went into effect on Jan. 24, 2006, according to an Oct. 10 letter from Assurant Health to the Connecticut Insurance Department. Gaskill says she bought the six-month policies instead of more traditional insurance because they were what she could afford.

In March, she went to the doctor for a small lump under her ear. It had been there awhile, but it did not hurt or bother her so she did not make an appointment until it seemed a bit larger than before.

The doctor asked how long she had the lump.

"I said 'maybe a year,' " says Gaskill, who has since moved to St. Petersburg, Fla. "I never thought that would be held against me."

The lump turned out to be cancer. After checking her medical records, Assurant revoked her policy, leaving her with \$30,000 in surgical bills.

In its letter to the insurance department, Assurant said it canceled the policy because "an ordinarily prudent person would seek diagnosis or treatment when a lump initially presents itself." Therefore, the lump was considered "pre-existing" and not covered under Gaskill's current six-month policy.

"I believe I'm a prudent person, but I didn't think I needed to see a doctor over this little thing," says Gaskill, who now has coverage through a state high-risk insurance pool.

Locker, a 61-year-old English teacher, also had a series of six-month policies with Assurant; she would re-apply each time one was about to expire.

Just days before one Assurant policy expired, Locker was diagnosed with a skin rash. Because she was tired and had lost some weight, her doctor also ordered a few lab tests, says a July 12 letter from Assurant to the Connecticut Attorney General's office.

The test results came back after her new six-month policy with Assurant went into effect. Those led to further tests, and, in the summer of 2005, she was diagnosed with lymphoma, a type of cancer. She received \$100,000 worth of chemotherapy and other treatment. Assurant revoked her policy, leaving her with those bills, saying her condition pre-existed her current policy and that her doctor should have been able to diagnose the condition earlier.

But, even if he had "diagnosed (Locker) under her prior policy, it would still be considered a pre-existing condition under the policy in question," the insurer said in its letter. "Short-term plans are not renewable. ... They are inexpensive gap insurance policies."

"I paid my bills in good faith every month with the understanding that if I were ever to have a catastrophic illness, I would not be without medical insurance," Locker says. "Then this is what I get?"

Locker has since been diagnosed with cancer in her liver and underwent a stem cell transplant this summer.

She now has a job teaching in a public school, which, unlike her former job at a private school, comes with health insurance, which covered the transplant.

Assurant Health, which also sells health insurance under the names Time Insurance, John Alden Life Insurance and Union Security Insurance, covers more than 1 million people nationwide.

A spokesman said the company would not comment on the Gaskill or Locker cases. In a written statement, Assurant said it is working with Connecticut's insurance department and attorney general's office: "While we can never discuss the details of individual cases, it is important to know that, when errors are found, we work with state regulatory agencies to rectify them quickly and efficiently."

Vigilant for fraud

Insurers say they have a detailed application process and the ability to rescind policies because they must be vigilant for fraud.

"We can only rely on what folks tell us," says Chris Ohman, president and CEO of the California Association of Health Plans, the industry lobby.

New regulations are not needed, says Ohman, pointing to the 200 complaints in the past several years — out of about 1.7 million policyholders statewide — filed against insurers on the issue of revoked policies. That indicates no widespread problem, he says.

Reasons for revocations vary. Most of the time, the decisions involve disputes over what the policyholder disclosed, or did not disclose, on the insurance application. Intentionally lying on an application is clearly a revocable offense, but not all disputes are that clear-cut.

In the Gaskill and Locker cases now before Connecticut regulators, the insurer does not say the policyholders misled the company, but it revoked the policies because the women should have known or suspected they had a disease, even without a diagnosis.

In California, cancellations have occurred because applicants, such as the Wheelers, left out information about a symptom unrelated to a current medical problem or did not disclose that a diagnostic test had been performed, even though the test ruled out problems.

Insurers say they are operating well within the law and are taking action to protect all policyholders.

Blue Cross of California, one of several plans being sued in California, says that it rescinds an average of 1,000 policies each year out of about 260,000 new individual enrollments — less than one-half of 1%, says spokeswoman Shannon Troughton.

"The issue here is how infrequently this happens," Troughton says. "Rescission is an important tool to protect against fraud. Fraud drives up costs for members and the health system in general."

Such disputes generally do not affect people in group health policies offered by employers, because insurers do not bar new members from group policies based on their health status. State laws also limit the amount of time a pre-existing condition can be excluded from coverage. On the individual market, there are generally fewer protections against pre-existing condition exclusions.

Pollitz at Georgetown says the individual market has some very complicated rules that applicants and insurers can get caught up in. At the root of the problem, she says, is that the market works best for people who are healthy.

"You're eligible for insurance when you don't need health care and not eligible when you do," she says. "Are people gaming? Maybe they are. Why were they gaming to begin with? They lost other coverage and need new coverage."

A typical application form asks applicants to look back at least 10 years and list conditions for which treatment was received. Some forms ask applicants to list "signs or symptoms" of disease as well.

Questions can arise on how to fill out the forms: Was the visit to the doctor eight years ago for tension headaches a reportable condition? What if the doctor said there was nothing wrong? What's an "abnormal physical exam?"

Insurers say their customer service lines or insurance salespeople can help; attorneys question whether such sources are unbiased.

Pollitz says insurers go beyond the application form to review medical records before issuing a policy in 25% to 50% of cases. Some also buy information, such as prescription records, from national databanks to find out if an applicant is being treated for illnesses not disclosed on the forms. The onus is on the insurer to do the proper underwriting, she says.

Attorney William Shernoff, who represents Wheeler, Seals and some other patients involved in the California legal disputes, says the forms are designed to be unclear, giving insurers cover to cancel almost any policy.

"I would venture to say that anyone who fills one out would make a mistake," Shernoff says. "They have compound questions, confusing questions, ambiguous questions. There's no place to answer 'I don't remember' or 'I don't know.' "

Troughton, at Blue Cross, says the insurer is working with regulators and plaintiffs attorneys to develop a new application form.

The insurer also has created a committee to review all revocations and will employ an ombudsman to help policyholders who face rescission.

"Ultimately, we wish we didn't have to rescind any policies, which is why we are committed to making the process as thoughtful and rigorous as possible," Troughton says.