

Today's hearing begins what I hope will be a series of hearings into how the market for individual health insurance policies works.

The individual health insurance market serves approximately 14 million Americans. Some members of Congress cite the individual market as a model for national health insurance reform. Yet the business practices of the companies that sell individual health insurance policies have never been closely examined by Congress.

Today's hearing will examine a little-known business practice in the individual health insurance market which the industry calls "post-claims underwriting." Post-claims underwriting is a sanitized name for an exceptionally offensive practice: retroactively denying health insurance to people who get sick.

Most Americans who have health insurance get that insurance through their employers or through government programs like Medicare, Medicaid, or Tricare. Americans who are fortunate enough to have group insurance are not at risk for post-claims underwriting. Group coverage can't be terminated when you need it most.

Americans who purchase health insurance in the individual market face a much different situation. In most states, insurers require applicants for individual health insurance to fill out detailed application forms that are designed to identify any physical or mental health conditions or chronic illnesses.

Insurers are supposed to review the information provided on these forms before approving the applicant for coverage. Based on this information, the insurer decides whether to issue the policy, to issue the policy with certain restrictions, such as refusing to cover pre-existing conditions, or to deny the application altogether. This process is called medical underwriting and the expectation is that it will occur before the policy is issued or denied.

Post-claims underwriting happens after the individual health insurance policy has been approved and issued. It is often triggered after the policyholder gets seriously ill or has a major accident. The insurer goes back through the application with a fine-tooth comb to see if there is

any technicality that can be used to justify rescinding the policy.

This happened to two of our witnesses, Heidi and Keith Bleazard. They will tell us how their health insurance was taken away after Heidi suffered serious injuries in a biking accident. Their insurer, Regence, claimed that Heidi and Keith had made a mistake in their application for health insurance and terminated their policy. They were left with more than \$100,000 in medical bills.

What happened to the Bleazards is inexcusable. The reason families buy insurance is so they will be covered when they get sick. But Regence cancelled their insurance when they needed it the most.

Unfortunately, the experience of the Bleazards is not an isolated one. We will hear today that over 1,000 individuals in California had their insurance policies inappropriately rescinded. And we will hear about policyholders in Connecticut who suffered the same thing. One person was terminated because the insurer said he should have known that his occasional headaches would later be diagnosed as Multiple Sclerosis.

I understand that insurance companies need to protect themselves from fraud. But that is not what happened in California, Connecticut, and across the country. Insurers are using technicalities or trumped-up “misrepresentations” to rescind policies after individuals get sick and accumulate hundreds of thousands of dollars in medical bills.

That’s a great deal for the insurers: they pocket the premiums while the family is healthy and cancel the coverage if anyone gets seriously ill. But it defeats the whole point of getting a health insurance policy in the first place.

While state regulators are the front line of defense for consumers, the federal government is the last line. Under HIPAA — the federal Health Insurance Portability and Accountability Act of 1996 — consumers are guaranteed the right to renew their individual health insurance policies unless they have defrauded the insurer or intentionally misrepresented their medical condition.

Unfortunately, few consumers know of their federal HIPAA rights to guaranteed renewability. That's because the federal agency responsible for enforcing HIPAA — the Centers for Medicare & Medicaid Services — has done nothing to enforce those rights or to ensure that states do so. Of its 4,387 full-time employees, only four are assigned to administering HIPAA. CMS has never taken any action against any health insurer for post-claims underwriting that violates a consumer's HIPAA rights.

Our hearing today will examine how the practice of post-claims underwriting is being abused to deny coverage to ailing Americans. We will learn what some state regulators are doing to stop the abuses.

We will ask why the federal government is doing nothing to protect consumers from this practice.

And we will ask the health insurance industry's trade association why insurers in the individual market do post-claims underwriting and why it has taken the intervention of regulators to bring an end to this unfair practice in some states.

These are not academic questions. Discussions are already underway about how the next Congress might best ensure that all Americans have adequate health care coverage. Some health care reform proposals would move millions of Americans, including many of those now insured through their employers, and billions of federal dollars, into the individual health insurance market.

This would obviously be a radical change in our health care system. Whether it represents reform is a debate for another day. To prepare for that debate, however, we all need a much better understanding of the individual health insurance market as it currently functions. The purpose of this hearing is to begin that educational process.