

RESCISSION OF HEALTH INSURANCE POLICIES AFTER HIPAA

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Introduction

The Health Insurance Portability and Accountability Act (“HIPAA”) was intended to expand the availability of group and individual health coverage.¹ HIPAA requires group and individual health insurers to provide coverage to individuals who, prior to its enactment, would not have met underwriting requirements because of their medical histories. In light of HIPAA, the only meaningful protection health insurers have against these substandard risks is the ability to charge higher than standard premiums, assuming that the applicable state insurance law permits such premium increases. This protective mechanism is, of course, highly dependent upon the health insurer obtaining accurate medical histories at the time group and individual risks are underwritten.

In the past, despite differences in the state law of rescission, health insurers could generally rely on the accuracy of medical histories reported on insurance applications. If an application contained meaningful misrepresentations, the group or individual health insurer could generally revoke the policy retroactively – rescind *ab initio*.

Since the effective date of HIPAA, it is no longer true that an insurer may refuse to issue a policy on the grounds that the medical history reported by the applicant renders the risk unacceptable. What remedy, then, does a health insurer have if an applicant makes material misrepresentations of medical history? One possible remedy is the retroactive imposition of a premium increase; however, even if such a retroactive premium increase is permitted under applicable state law, this option, alone, is inadequate because it would promote dishonesty in the disclosure of relevant medical history. If the insurer’s only option is to increase premiums retroactively so that the insured pays the amount that would have been required had an accurate medical history been given, apart from the largely theoretical possibility of criminal prosecution, the insured faces no penalty for having attempted to commit a fraud. If the misrepresentation is not uncovered, the insured is rewarded by receiving coverage for a lower premium than would have been charged had complete and accurate medical information been given. As such, a far more meaningful remedy for the insurer would be the ability to rescind the policy and, thus, avoid the risk entirely, which pre-HIPAA was permitted in all states for, at least, fraudulent material misrepresentations. The status of such rescission *ab initio* is unclear in light of HIPAA. As of this writing, there exist no reported decisions which detail an insurer’s rescission rights in light of HIPAA.

Rescission of Health Insurance Coverage Under State Law

This article does not purport to address the subtleties and nuances of each state’s law applicable to the rescission of health insurance policies. Instead, it sets forth certain general principles of rescission that are applicable in the majority of states and discusses how HIPAA may affect these principles.

In general, an insurance policy, including a health insurance policy, may be rescinded on the basis of material misrepresentation, *i.e.*, a misrepresentation that materially affects the risk assumed, even if the misrepresentation was made without an intent to deceive.² In most states, rescission is permitted based upon a material misrepresentation even if benefits are being sought on grounds unrelated to the misrepresented fact.³ This general rule affirmatively promotes full and complete disclosure of medical history, while the minority rule requiring a causal connection between the loss and the misrepresented fact encourages a lack of forthrightness since it results in coverage in circumstances where the risk would otherwise have been rejected or, at least, a higher premium charged for the coverage. The majority rule is that misrepresentations affecting only the premium charged permit rescission and the avoidance of liability on the policy.⁴ Again, permitting rescission and retroactive avoidance of liability in such circumstances promotes full and complete disclosure of adverse medical history by insureds.

Guaranteed Availability and Continuation of Health Coverage Under HIPAA

HIPAA recognizes three distinct markets for health insurance coverage – the large employer group market, the small employer group market, and the individual market.⁵ The availability of health coverage is guaranteed by HIPAA in the

small employer group market and to certain persons in the individual market.⁶ While the large employer group market is not extended this same protection, HIPAA significantly impacts on all health insurance issuers in any of the health coverage markets by eliminating their traditional right to reject risks on the basis of “health status-related factors.”⁷ Factors which cannot be used as a basis for rejecting a risk include health status, medical condition, claims experience, receipt of health care, medical history, genetic information, and evidence of insurability and disability.⁸ The guaranteed availability mandate of HIPAA is less significant for insurers in the individual market because of the applicable HIPAA definition of “eligible individual” with respect to this market. “Eligible individuals,” for purposes of the individual market, are generally persons who (i) have had 18 or more months of prior health care coverage and who, most recently, lost coverage under an employer group health plan, (ii) are not eligible for coverage by another group health plan, and (iii) who do not have any other health insurance coverage.⁹ HIPAA allows states to adopt their own mandatory issuance rules for individual health insurers, subject to certain minimum requirements, namely, that all “eligible individuals” within the meaning of HIPAA are guaranteed access to coverage.¹⁰ Thus, in those states which have enacted their own legislation, “health status-related factors” within the meaning of HIPAA nonetheless cannot be used to deny coverage to applicants who are “eligible individuals.”

HIPAA is also designed to ensure that once health coverage is obtained, the insured may keep the coverage in place indefinitely. As a general rule, an insurer must renew or continue in force health coverage at the option of the plan sponsor or plan (group markets) or the option of the insured individual (individual market).¹¹

While HIPAA mandates coverage for many substandard risks, raising concerns about adverse selection, it does not prohibit health insurers from taking into account “health status-related factors” in establishing premium rates. Nonetheless, because HIPAA does not preempt the right of the states to impose rate regulation, the ability of health insurers to protect themselves through premium rates will vary from state to state.

Discontinuation of Coverage Under HIPAA Due to Misrepresentation

Under HIPAA a health insurer may “nonrenew or discontinue” coverage if the plan sponsor or insured individual, as applicable, “performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.”¹² These provisions could be narrowly construed as permitting discontinuance of coverage for misrepresentations in the application for that coverage only for common law fraud.¹³ It could be argued that discontinuance of coverage for “intentional misrepresentation of material fact” relates only to misrepresentations that are made in an attempt to obtain benefits after effective coverage is in place, *i.e.*, a misrepresentation “under the terms of coverage.” The better construction is that intentional misrepresentation in the application for coverage constitutes grounds for discontinuation. HIPAA does not clearly eliminate the traditional right of insurers to rescind coverage or avoid liability due to material misrepresentations in the application for coverage. The elimination of this right would affirmatively encourage misrepresentation by applicants for health coverage and it should not be concluded, absent the clearest statutory language to the contrary, that HIPAA precludes discontinuation of coverage if the plan or individual has made material misrepresentations in the application for coverage.

In fact, it is at least arguable that rescission of a health policy *ab initio* is not permitted under HIPAA. HIPAA’s use of the term “discontinue” (implying an effective policy) and the absence of the term rescission, could be construed as eliminating the right to rescind coverage *ab initio*. This argument is bolstered by the fact that other events which permit an insurer to “discontinue” coverage under HIPAA are prospective or, at most, partially retroactive.¹⁴

Clearly, the term “discontinue health insurance coverage” need not necessarily be interpreted to preclude retroactive discontinuation through rescission. To interpret HIPAA as permitting only prospective elimination of coverage upon discovery of material misrepresentation or fraud would encourage dishonesty, and presumably, Congress did not intend to condone fraud or intentional misrepresentation. The only remedy that can fully rectify the wrong of a misrepresentation that induced coverage is to permit rescission of that coverage *ab initio*.

HIPAA Preemption and Rescission Under State Law

In general, an action by a health insurer permitted by applicable state law is not invalidated by HIPAA unless that state insurance law would prevent a provision of HIPAA from becoming effective in that state.¹⁵ Because HIPAA does not

expressly preclude rescission as a remedy for material representation, and because HIPAA expressly permits discontinuance of coverage as a consequence of an intentional misrepresentation, state law rescission remedies should not be deemed to prevent the “application of HIPAA.”

Further, if Congress had intended to eliminate state law rescission remedies, one would have anticipated an express statutory statement of this intent. In the absence of such an express statement (and the presumption that HIPAA was not enacted so as to permit persons to make misrepresentations on applications for coverage) allowing rescission does not prevent the “application of HIPAA.”

What about state laws that permit rescission for unintentional material misrepresentations? In this context, insureds have a much stronger argument that state laws permitting such rescissions prevent the application of HIPAA, and, as such, are preempted. HIPAA only permits nonrenewal or discontinuance of coverage for “fraud or intentional misrepresentation of material fact.” While insurers could still argue that HIPAA simply does not address rescission so that the underlying state law is applicable, it is likely that the federal courts would conclude that rescission is only available for fraud or intentional misrepresentation of material fact.

In some circumstances, HIPAA may ultimately be construed as broadening rights to rescind coverage that are not presently recognized by the law of some states. Presumably, the word “material” within the meaning of HIPAA will be construed uniformly throughout the United States and will not be held to turn on how the term is used in the state whose law might otherwise be applicable. The rule adopted in the overwhelming majority of states is that a misrepresentation is “material” if it affects the premium charged for the coverage. If the majority rule is adopted for purposes of HIPAA, then contrary state law should be preempted as a “standard or requirement” which prevents the application of a part of HIPAA, *i.e.*, rescission based on a material misrepresentation, as “material” is construed within the meaning of HIPAA. Another area of possible preemption might be the laws of the minority of states that require a causal connection between the misrepresented fact and the loss for the misrepresentation to be deemed “material.” Cases decided under ERISA, creating a federal common law applicable to insurers who issue group health policies to employee benefit plans, should generally be deemed applicable in construing HIPAA. In this regard, several federal court decisions have rejected a materiality test that requires a causal connection between the misrepresented fact and the loss.¹⁶

The scope of an insurers right to discontinue health insurance coverage under HIPAA is presently unclear. The extent of this right in light of HIPAA will have to await judicial, statutory or regulatory clarification.

Endnotes

1. In an effort to regulate the provision of health care benefits to all individuals, Congress, in passing HIPAA, amended the Employee Retirement Income Security Act of 1974 (“ERISA”), as amended, 29 U.S.C. § 1001, *et seq.*, the Internal Revenue Code of 1986 (the “Code”), as amended, 26 U.S.C. § 1, *et seq.* and the Public Health Services Act (“PHSA”), as amended, 42 U.S.C. § 201, *et seq.* The provisions of ERISA generally apply to all group health plans other than church plans or government plans and health insurance issuers that offer health insurance coverage in connection with group health plans. The provisions of the Code apply to all group health plans other than church plans, but not to health insurance issuers. The provisions of the PHSA generally apply to health insurance issuers, and certain state and local government plans. The citations in this article are to ERISA, although parallel provisions exist in both the Code and the PHSA.
2. *E.g.*, *Thompson v Occidental Life Ins. Co. of California*, 9 Cal.3d 904; 109 Cal. Rptr. 473; 513 P.2d 353 (1973), *Continental Assurance Co. v Carroll*, 485 So.2d 406 (Fla. 1986), *Unger v Metropolitan Life Ins. Co.*, 103 Ill. App. 2d; 242 N.E. 2d 907 (1968), *Legel v American Community Mutual Ins. Co.*, 201 Mich. App. 617; 506 N.W. 2d 530 (1993), *Prudential Ins. Co. v Anaya*, 79 N.M. 101; 428 P.2d 640 (1967). *Contra*, requiring an intent to deceive as a condition for rescission, *Marchiori v American Republican Ins. Co.*, 662 A. 2d 932 (Me. 1995), *Union Bankers Ins. Co. v Shelton*, 889 S.W. 2d 278 (Tex. 1994), *Powell v Time Ins. Co.*, 181 W. Va. 289; 382 S.E. 2d 342 (1989).
3. *E.g.*, *National Life & Accident Ins. Co. v Atha*, 69 Ga. App. 825; 26 S.E.2d 675 (1943), *Wickersham v John Hancock Mutual Life Ins. Co.*, 413 Mich. 57; 318 N.W. 2d 456 (1982), *Massachusetts Mutual Life Ins. Co. v Manzo*, 122 N.J. 104; 584 A.2d 190 (1991), *Reisen v Blue Cross Blue Shield of Oregon*, 115 Or. App. 396; 839

P. 2d 729 (1992), *Carroll v Jackson National Life Ins. Co.*, 307 S.C. 267; 414 S.E. 2d 777 (1992), *Berger v Minnesota Mutual Life Ins. Co.*, 723 P. 2d 388 (Utah 1986). *Contra*, requiring a causal connection between the misrepresented fact and the loss, *Central National Life Ins. Co. v Peterson*, 23 Ariz. App. 4; 529 P. 2d 1213 (1975).

4. *E.g.*, *Oakes v Blue Cross Blue Shield of Columbus, Inc.*, 170 Ga. App. 335; 317 S.E. 2d 315 (1984), *Hatch v Woodmen Accidents & Life Ins. Co.*, 88 Ill. App. 3d 36; 409 N.E. 2d 540 (1980), *Keys v Pace*, 358 Mich. 74; 99 N.W. 2d 547 (1958) (but see, *contra*, *Zulcosky v Farm Bureau Life Ins. Co. of Michigan*, 206 Mich. App. 95; 520 N.W. 2d 336 (1994)), *Rondono v CUNA Mutual Ins. Co.*, 106 Nev. 371; 793 P. 2d 1324 (1990). *See also, contra*, *Harrington v Aetna Casualty and Surety Co.*, 489 S.W. 2d 171 (Tex. Civ. App. 1973).
5. The large group market consists of employers who employed an average of at least 51 employees during the preceding calendar year and who employed at least 2 employees on the first day of the plan year. 42 U.S.C. § 300gg-91(e)(2) and (3). The small group market consists of employers who employed an average of 2 but not more than 50 employees during the preceding calendar year and who employed at least 2 employees on the first day of the plan year. 42 U.S.C. § 300gg-91(e)(4) and (5). The individual market “means that the market for health insurance coverage offered to individuals other than in connection with a group health plan.” 42 U.S.C. § 300gg-91(e)(1).
6. 42 U.S.C. § 300gg-11(a) (small group market); 42 U.S.C. § 300gg-41(a) (individual market).
7. 42 U.S.C. § 300gg-1(a) (group markets); 42 U.S.C. § 300gg-41(a) (individual market).
8. 42 U.S.C. § 300gg-1(a).
9. 42 U.S.C. § 300gg-41(b).
10. 42 U.S.C. § 300gg-44.
11. 42 U.S.C. § 300gg-12(a) (group markets); 42 U.S.C. § 300gg-42(a) (individual market). There are limited exceptions to this obligation which are discussed, *infra*.
12. 42 U.S.C. § 300gg-12(b)(2) (group markets); 42 U.S.C. § 300gg-42(b)(2) (individual market).
13. Where only an intentional misrepresentation is required, the actor’s intent or good faith is immaterial. Fraud, however, requires evidence of an intent to deceive. *See Couch on Insurance* 3d, § 31.81; § 31.82.
14. Discontinuance of coverage is also permitted for (i) nonpayment of premiums; (ii) violation of participation or contribution rules in the case of group insurance, (iii) the insurer’s termination of all health coverage within a particular market in any state; (iv) movement of all insured participants (group plans) or the insured individual outside the service area in the case of a network plan and (v) in the case of coverage based on association membership, the cessation of such membership. *See*, 42 U.S.C. § 300gg-12(b) (group markets); 42 U.S.C. § 300gg-42(b) (individual market).
15. 42 U.S.C. § 300gg-23(a)(1) provides that HIPAA “shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.” To similar effect, for individual coverage, *see* 42 U.S.C. § 300gg-62(a).
16. *See, e.g., Davies v Centennial Life Ins. Co.*, 128 F.3d 934 (6th Cir. 1997).