Intensive Care for Health Care Service Plans: Addressing the Growing Problem of Post-Claims Underwriting and Rescissions by Plan Providers

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Table of Contents

INTRODUCTION: ......................................................................................................................... 1
I. HEALTH CARE SERVICE PLANS AND POSTCLAIMS UNDERWRITING...................... 2
   A. Individual Health Care Service Policies ................................................................. 2
      1. Underwriting Generally .................................................................................. 3
      2. Postclaims Investigations................................................................................ 3
      3. Postclaims Underwriting.................................................................................. 4
   B. Laws and Regulations Applicable to Individual Health Care Service Plans ........... 5
      1. Laws of Contract.............................................................................................. 5
      2. Knox-Keene Act ............................................................................................. 6
      3. Health Insurance Access and Equity Act and Section 1389.3 ......................... 6
II. HAILEY V. CALIFORNIA PHYSICIANS’ SERVICE ...................................................... 7
III. ANALYSIS OF THE COURT OF APPEAL DECISION IN HAILEY ................................. 13
   A. Medical Underwriting Under Section 1389.3 ...................................................... 13
      1. Health Care Service Application .................................................................. 16
   B. Willful Misrepresentation Under Section 1389.3 ................................................. 16
      1. Steve Hailey’s Medical Records .................................................................... 18
   C. Rescission as an Equitable Remedy ................................................................... 19
   D. Intentional Infliction of Emotional Distress......................................................... 21
   E. Recent Developments in the Hailey Case ......................................................... 22
IV. UNDERLYING PUBLIC POLICY ARGUMENTS............................................................. 24
   A. Health Care in California .................................................................................. 24
      1. Development of Health Care in California ..................................................... 24
      2. Necessity of Postclaims Investigations............................................................ 26
   B. Fallout of Hailey Decision on Enforcement of Section 1389.3 ......................... 30
      1. Immediate Effects ......................................................................................... 30
      2. Potential Impact ............................................................................................. 31
V. CONCLUSION....................................................................................................................... 34
INTRODUCTION:

In recent years, thousands of patients have been left without health care coverage – their plans rescinded or canceled after health care providers investigated the patients’ prior medical histories.¹ These rescission investigations are often conducted after the patient has become ill or injured, receives treatment and files a claim. This practice, commonly known as post claims underwriting, leaves vulnerable patients without coverage at a time when coverage is needed most. Although state and federal laws regulate the underwriting process, state health care departments must enforce these regulations. At least a dozen states prohibit post-claims processing through laws requiring underwriting be completed at the time of the policy application, while a few other states prohibit the practice without any formal regulation.² Some states, such as California, have enacted statutes that specifically identify and prohibit “postclaims underwriting.”³ Despite state regulations that prohibit the practice, states have varied in their enforcement of these regulations and courts have been varied in their interpretation. Through a case study of a recent California case, Hailey v. California Physicians Service,⁴ this Article examines the practice of post-claims underwriting, the effect of state laws prohibiting the practice, the role of the courts in interpreting these laws, and the impact of recent case law on the health care industry. The Hailey case not only represents a turning point in the application of these statutes to the health care industry, but it helps to demonstrate the real world dilemmas that led to the original passage of California’s statute prohibiting post-claims underwriting, section 1389.3. The current application of this statute relies not only on its’ plain language, but has also been heavily influenced by issues of contract law intermixed with insurance law, recent case law

and pressing issues of public policy. Although lower courts have previously split on issues of postclaims underwriting under section 1389.3, the decision in *Hailey* represents a well-reasoned analysis, relying on statute, legislative intent and a detailed analysis of policy issues. Given the progressive nature of California’s health care statutes and regulations, the impact of the *Hailey* decision on section 1389.3 will likely echo throughout the U.S. health care industry.

Part I of this article discusses the health care policy underwriting process, the practice of post-claims underwriting and the laws and regulations which govern health care service plans, and in particular California Health and Safety Code section 1389.3. Part II examines the background of the *Hailey* case, which highlights the problems associated with post-claims underwriting, the enforcement of regulations prohibiting the practice, and the California court’s interpretation of the regulations. Part III analyzes the court’s decision, its effect on the practice of post-claims underwriting and underwriting in general. Part IV then discusses the immediate effects and potential impact of the *Hailey* decision on the health care industry in general.

I. HEALTH CARE SERVICE PLANS AND POSTCLAIMS UNDERWRITING

A. Individual Health Care Service Policies

Whereas employee-sponsored group plans charge all members standard rates and are required to accept all applicants regardless of risk, individual plans can vary premiums according to risk levels and can deny applicants based on unacceptably high levels of risk. The process by which an applicant’s eligibility and risk level is determined is referred to as underwriting. The underwriting process is intended to ensure low premiums, safeguard the solvency of the system and ensure quality health care. While group policies are subsidized by employers who typically share the costs of coverage, individual policies are paid for solely by the individual, which is why sustaining affordable premiums is so important.

5 Individual policy applicants in California undergo underwriting for health insurance or health care service plans.
1. Underwriting Generally

The process of underwriting involves three main steps: 1) risk selection; 2) risk classification and 3) charging adequate premiums to policyholders.6 Risk selection involves determining what risks an insurer is willing to cover. Applicants having high risks factors such as obesity, heart disease, and cancer are typically rejected by most policy providers. Risk classification involves “grouping together individual applicants . . . who have similar risk characteristics and share a similar level of expected medical costs.”7 A low-risk group would receive the “premier” rate, while a high-risk group would pay a considerably more costly rate. If similarly situated individuals are not grouped accordingly or certain individuals misrepresent their medical conditions, then the healthier individuals subsidize those with higher risks – a problem which may lead to higher premiums or risk insolvency for policy providers. Premium selection involves looking at the actual historical risk, the prices of health care in a particular area and charging a premium which will encourage a larger number of people to apply for coverage, while ensuring the policy provider remains financially stable enough to pay out claims. Generally, once the provider receives the application, these factors have been analyzed, and the applicant is accepted or rejected, providers consider underwriting complete.

2. Postclaims Investigations

According to the California HealthCare Foundation, in 2007, approximately 56% of covered Californians were enrolled in group plans under their employer, while only 8% had purchased individual plans.8 Although individual plans only account for only a small percentage, the returns and profits from individual plans are significantly higher relative to group

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7 Id. at 3.
plans. The efficiency of individual plans is considerably higher providers can deny high-risk applicants and utilize tiered premiums according to risk. As a result, applicants with higher than average risk factors may have difficulty finding health coverage or may have to pay relatively high premiums. This leads some applicants to misrepresent certain conditions in an attempt to get coverage they might not otherwise be eligible for. Not only does this decrease the efficiency of individual plans, but if uncontrolled, applicant fraud can reduce the quality of care, raise premiums or threaten the solvency of the provider. To counter potential applicant fraud, many health insurers and health care service plan providers conduct targeted investigations to weed out potential cases of fraud or misrepresentation. To efficiently utilize resources, providers only investigate policyholders when there is some indication of possible fraud. Medical expenses that exceed the average expenses for policyholders in a risk category are one indicator of potential fraud or misrepresentation. Once found, those policies can be rescinded, canceled or limited by moving the applicant into a higher-risk category.

3. Postclaims Underwriting

Postclaims underwriting refers to the practice of waiting until a claim is filed before making decisions regarding eligibility for coverage that should have been made during initial underwriting. This practice includes requesting information from the applicant before the policy issues, but not examining that information until after a claim is made. Often, an insurer or provider will begin an investigation after a claim is filed in an attempt to dig up any previously unknown risks or misrepresentations in order to cancel or rescind the contract. Insurers often rely on postclaims underwriting to avoid paying a claim, allowing them to effectively avoid the risk they contracted to undertake and shift the risk back to the consumer. The consumer is often

\footnote{Hailey, 158 Cal. App. 4th at 465.}

\footnote{Id. at 454-5.}
left unable to cover the loss and potentially unable to find coverage at rates they could have obtained had they been rejected during initial underwriting. Often times the misrepresentation may be minor and have no relation to the medical loss, which precipitated the investigation. The plain language of section 1389.3 seeks to define and prohibit postclaims underwriting in attempt to shift the risk back to the policy providers and protect consumer interests.

Theoretically, postclaims underwriting involves decisions that should have been made during the initial underwriting, whereas postclaims investigations may occur only after the initial underwriting is properly completed. The distinction between these two types of investigations appears to be semantics at best. In practice, the main difference between postclaims investigations and postclaims underwriting seems to perspective more than anything else – insurers and policy providers fight to label postclaims underwriting as a lawful “investigation.”

**B. Laws and Regulations Applicable to Individual Health Care Service Plans**

1. **Laws of Contract**

   A health care service plan is first and foremost a contract, subject to its own terms and the laws of contract. If a health care plan fails to perform the bargained for terms of the contract, as the Haileys claim Blue Shield has done here, it is liable for breach of contract. Both parties to the contract are also bound by the duty of good faith and fair dealing. If an applicant makes a material misrepresentation, however, then the provider may be able to rely on the equitable remedy of rescission to avoid the contract. Unless otherwise preempted by statute, rescission is a remedy available for all civil contracts in California.\(^{11}\) California law provides that a party may rescind if the consent of the rescinding party was “given by mistake, or obtained through duress, menace, fraud, or undue influence, exercised by or with the connivance” of the other party.\(^{12}\)

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\(^{12}\) Id.
2. Knox-Keene Act

In 1975, partly in response to the abuses by HMOs and other health care service plans, the California legislature passed the Knox-Keene Health Care Service Plan Act with the legislative intent of promoting “the delivery and quality of medical care to the people of the State of California.”\(^\text{13}\) Incorporated into the California Health and Safety Code, the Knox-Keene Act’s goals include ensuring the “best possible health care for the public at the lowest possible cost by transferring the financial risk of health care from patients to providers” and delivering health services in a “manner providing continuity of care.”\(^\text{14}\)

Before the Knox-Keene Act, health care service plans were governed by the California Insurance Code. In an attempt to move the health care toward HMOs or service plans, the Knox-Keene Act established the California Health and Safety Code as the regulatory framework for health care service plans. Initially, the California Health and Safety Code incorporated a large portion of the existing insurance code.\(^\text{15}\) Absent legislation specific to health care service plans, courts often rely on the Insurance Code and corresponding case law in the context of health care service plans.

3. Health Insurance Access and Equity Act and Section 1389.3

In furtherance of the Knox-Keene Act goals of ensuring the “transferring the financial risk of health care from patients to providers,” the legislature passed the Health Insurance Access and Equity Act.\(^\text{16}\) This act regulated a variety of access and coverage issues regarding both health insurance and health care service plans. One statute in particular, the Cal. Health and Safety Code §1389.3, addressed the growing problem of post-claims underwriting. Section 1389.3 reads in its entirety:

\(^{14}\) Id. at (d) and (g).
\(^{15}\) Telephone Interview with Michael Nutter.
\(^{16}\) Hailey, 158 Cal. App. 4th at 453.
No health care service plan shall engage in the practice of postclaims underwriting. For purposes of this section, "postclaims underwriting" means the rescinding, canceling, or limiting of a plan contract due to the plan's failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the plan contract. This section shall not limit a plan's remedies upon a showing of willful misrepresentation.

The Department of Health Care has been tasked with enforcement of section 1389.3 and other provisions of the California Health and Safety Code applicable to health care service plans. Although the department’s interpretation of the statute is not controlling on the court’s analysis, its interpretation certainly carries great weight in the Court of Appeals’ decision. Since its passage in 1993, section 1389.3 had been unevenly enforced and California courts had been divided as to what constituted postclaims underwriting. One recent case, Hailey v. California Physicians’ Service, has resolved much of the confusion regarding postclaims underwriting.

II. HAILEY V. CALIFORNIA PHYSICIANS’ SERVICE

Cindy and Steve Hailey lived with their 18-year-old son, Scott, in Cypress, California, a suburb on the northern edge of Orange County. Cindy, a temporary worker with a high school education, worked as a manager at Powerwave Tech through her staffing agency, ProStaff; while her husband Steve worked as a self-employed machinist specializing in hydraulic presses. At the end of 2000, Cindy changed jobs and became a branch manager of the Santa Anna and Garden Grove offices in the sales department of Sharp Staffing. After changing jobs, Cindy temporarily continued ProStaff’s group health insurance coverage for her family through

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17 Telephone Interview with Michael Nutter.
18 Hailey Application for Blue Shield Individual/Family Plan at 1 (see Attachment 1).
20 Hailey Application at 1; Telephone Interview with Michael Nutter, Attorney for Petitioners, in Santa Ana, Cal. (Oct. 8, 2008); E-mail from Michael Nutter, Attorney for Petitioners, to Kenneth Shurtz, UC Hastings student (Jan. 7, 2009) (on file with author).
21 E-mail from Michael Nutter; Cindy Hailey’s Job History profile, supra note 2.
COBRA\textsuperscript{22} while she looked for new coverage.\textsuperscript{23} Although Cindy believed Sharp Staffing would extend her family coverage, her existing physician was not covered by their plan. Cindy continued to look for a plan that would enable her to continue treatment for an irritable bowel condition under her current doctor. After learning her physician was covered through health care service plans offered by Blue Shield of California (“Blue Shield”),\textsuperscript{24} she contacted an insurance agent for an application.\textsuperscript{25} Cindy filled out and signed the application, and then had Steve and Scott sign the application before mailing the forms to the insurance agent. Although Cindy believed she had provided all the requested information, in fact, she had only provided her own health history, neglecting to include any health information about her husband, Steve, or her son, Scott.\textsuperscript{26} Though the application specifically requested medical information about the applicant “or any applying family member,”\textsuperscript{27} Cindy claims that she “mistakenly believed” only her health information was required and not that of her husband or son.\textsuperscript{28} In addition to omitting her husband’s health history, she “incorrectly listed Steve’s weight as 240 pounds instead of his actual weight of 285 pounds.”\textsuperscript{29} While the insurance agent reviewed the application and questioned Cindy about her health history, he did not go over the questions in detail nor did he ask about her husband’s or son’s health; after the agent entered the application information into

\begin{footnotes}{
\footnote{\textsuperscript{22} Hailey, 158 Cal. App. 4th at 460; The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) allows for temporary continuation of group health coverage at group rates after termination of employment. See http://www.dol.gov/ebsa/faqs/faq_consumer_cobra.HTML.}
\footnote{\textsuperscript{23} Hailey Application at 1.}
\footnote{\textsuperscript{24} California Physician’s Service does business as Blue Shield of California. California Physician’s Service is referred to throughout this Article as Blue Shield of California. See Hailey, 158 Cal. App. 4th at 459.}
\footnote{\textsuperscript{25} Id.}
\footnote{\textsuperscript{26} Id. at 460.}
\footnote{\textsuperscript{27} Id. at 464.}
\footnote{\textsuperscript{28} Id. at 460-1.}
\footnote{\textsuperscript{29} Id. at 460.}}
the online system, Blue Shield accepted the application and offered the Hailey family coverage at the lowest, “premier rate” on December 15, 2000.\(^{30}\)

Less than two months later in February of 2001, Steve sought treatment at a hospital for stomach problems. Unknown to the Haileys, once hospital filed a claim for Steve’s treatment, Blue Shield sent the Haileys’ application to its “Underwriting Investigation Unit” to investigate “potential fraud.”\(^{31}\) By early March, the investigation unit had received Steve’s medical records that revealed before December of 2000, he suffered from multiple health issues, “including obesity, hypertension, difficulty swallowing, and gastroesophageal reflux disease,” none of which had been reported on the application.\(^{32}\) Steve’s medical records also revealed that, as recently as October of 2000, he had been admitted to an emergency room, complaining of difficulty in swallowing. He was treated for “dysphagia, stricture/stenosis of the esophagus, [and] essential hypertension.”\(^{33}\) Blue Shield’s investigation found that Blue Shield had properly complied with its own underwriting policies during the application process and concluded that the Haileys had “intentionally misrepresented and concealed Steve’s medical information.”\(^{34}\) Despite these findings, Blue Shield did not rescind or cancel the policy, nor did they notify the Haileys of the investigation.\(^{35}\)

On March 19, 2001, less than a month after the investigation was complete, Steve was severely injured in an automobile accident leaving him disabled and hospitalized for over two months. Blue Shield authorized Steve’s surgery, treatment and physical therapy, costing in excess of $457,000.\(^{36}\) Once Steve was discharged from the hospital, Blue Shield sent a letter to

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\(^{30}\) Id. at 461.
\(^{31}\) Id.
\(^{32}\) Id.; Telephone Interview (regarding timing of Blue Shield investigation).
\(^{33}\) Hailey, 158 Cal. App. 4th at 461.
\(^{34}\) Id. at 461; Telephone Interview (regarding Blue Shield’s inaction and failure to notify).
\(^{35}\) Hailey, 158 Cal. App. 4th at 461.
\(^{36}\) Id. 

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the Haileys informing them their policy was “cancelled retroactively to December 15, 2000,” the policy’s date of issuance, due to the Haileys’ concealment of Steve’s medical history. The letter also demanded the Haileys pay Blue Shield $60,777.10 for costs already incurred on account of Steve’s medical care.

Burdened with mounting requests for payment from both the hospital and Blue Shield, the Haileys were unable to afford continuing medical care and physical therapy. Although Steve attempted to return to work from a wheelchair, his physical condition deteriorated, preventing him from continuing to work. Steve claims that as a result of not receiving necessary medical care he has suffered increased pain and required additional surgeries; his ability to walk has been impaired and he has permanently lost the use of his bladder. In January of 2003, the Haileys brought suit against Blue Shield for “breach of contract, breach of the implied covenant of good faith and fair dealing, and intentional infliction of emotional distress.” The Haileys maintain that Blue Shield’s rescission of their policy after Steve’s hospitalization was unlawful practice known as postclaims underwriting. The statute the Haileys’ complaint relies upon is California Health and Safety Code 1389.3, which states in part that “[n]o health care service plan shall engage in the practice of postclaims underwriting.”

Blue Shield argues that the rescission of the contract was legal because medical underwriting had been completed and the Haileys made material misrepresentations in their

37 Id.
38 Although Blue Shield had authorized care in excess of $457,000, they had not actually paid that amount. Third party medical providers were still owed additional amounts, and those parties attempted separately to recover those costs from the Haileys.
40 E-mail from Michael Nutter.
41 Hailey, 158 Cal. App. 4th at 462; Since the decision, Steve had electrodes placed in his spine for pain management will likely undergo surgery for replacement of his bladder with an Indiana pouch. E-mail from Michael Nutter.
application. Further arguing that it cannot be held liable for distress caused by asserting its legal rights, Blue Shield demurred as to the claim for intentional infliction of emotional distress and moved for summary judgment as to the remaining claims. Blue Shield also filed a cross-complaint seeking declarations that the health care contract was legally rescinded and that Blue Shield was entitled to recover the costs associated with Steve’s care.

Superior Court Judge Corey Cramin sustained the demurrers without leave to amend, failing to recognize a cause of action for intentional infliction of emotional distress in the context of a health care provider’s lawful rescission of a policy. Judge Cramin also granted summary judgment for Blue Shield on the remaining claims and entered judgment on Blue Shield’s cross-complaint finding that the “Haileys’ misrepresentations and omissions justified rescission.”

The Haileys appealed the decision to the Court of Appeal for the Fourth District of California and filed a petition to stay execution of Blue Shield’s judgment. The Court of Appeal granted de novo review of the trial court’s grant of Blue Shield’s demurrer and motion for summary judgment. Before the appeal was heard, the Court of Appeal requested amicus curiae briefs from various organizations. Those submitting amicus briefs for Blue Shield included: the California Association of Health Plans and the Association of California Life and Health Insurance Companies. Those submitting amicus briefs in support of the Haileys included: United Policyholders, a non-profit organization representing policyholder’s interests; the Shernoff firm, a law firm that has represented 70 individual rescission cases against Blue Cross and Wellpoint Health Networks; the California Medical Association, which is, ironically, the

44 Id. at 462.  
45 Id.  
46 Id.  
47 Id.  
48 Hailey, 158 Cal. App. 4th at 462.
founder of Blue Shield of California; and the Department of Managed Health Care, the state regulatory enforcement agency for the Knox-Keene Health Care Service Plan Act. Each of these briefs represented unique, often conflicting viewpoints of California’s health care industry.

In the trial court’s grant of Blue Shield’s summary judgment motion, the lower court held that Blue Shield’s rescission of the policy was lawful warranted by evidence that conclusively showed the Haileys had willfully misrepresented their health history on the application. The Court of Appeal, however, held that Cindy’s claim that she misunderstood the application was plausible, therefore, there was a triable issue of fact as to willful misrepresentation. The Court of Appeal then determined that the California’s legislature intended section 1389.3 to require a “reasonable check on the information the insurer uses to evaluate the risk.” Rejecting Blue Shield’s argument that mere acceptance of the application was sufficient to complete underwriting, the court held that section 1389.3 applied to limit Blue Shield’s remedies to any misrepresentations. The court notes that a duty of reasonable investigation in underwriting arises from public policy, equitable considerations and the legislative intent of the statute. According to the plain language of the statute, the underwriting and reasonable investigation must be completed before the policy issues. The court also calls into question rescission as an equitable remedy in the context of a health care services plan, noting that in the Haileys’ case, rescission failed to restore both parties to their former position. Rescinding the Haileys’ policy left them in a far worse position, than if they had been rejected by Blue Shield and sought insurance elsewhere.

50 Hailey, 158 Cal. App. 4th at 463-5.
51 Id. at 466-467.
52 Id. at 466-467.
53 Id. at 471.
The court also recognized a cause of action for intentional infliction of emotional distress even when a party is asserting their legal rights. The court notes a special relationship between policy providers and policyholders, particularly in circumstances where the policyholder’s health is at issue. Disregard for the policyholder’s circumstances and the consequences of rescission may be an abuse of that relationship. The court takes special notice of Blue Shield’s timing of its rescission, observing that Blue Shield waited until Steve incurred significant medical expenses before rescinding the policy. Even if the rescission was lawful, Blue Shield’s knowledge of the serious medical conditions involved and the likely emotional trauma rescission would cause combined with the timing of the rescission could subject Blue Shield to liability for intentional infliction of emotional distress.

III. ANALYSIS OF THE COURT OF APPEAL DECISION IN HAILEY

The Court of Appeal had a host of issues to decide in reviewing the lower court’s grant of Blue Shield’s demurrer and motion for summary judgment. The legal issues at hand included: the applicability of section 1389.3 to so-called postclaims investigations, the requirements for medical underwriting and willful misrepresentation, the availability of rescission as an equitable remedy, and whether intentional infliction of emotion distress applies to a policy providers’ assertion of its legal rights.

A. Medical Underwriting Under Section 1389.3

The court first had to determine whether section 1389.3 of the California Health and Safety Code applied to Blue Shield’s rescission of the Haileys’ policy. This inquiry required the court to examine what legally constitutes “failure to complete medical underwriting and resolve all

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54 Id. at 474.
55 Id.
reasonable questions” arising from the application to determine if Blue Shield’s acts are
postclaims underwriting.\footnote{56 Cal. Health & Saf. Code § 1389.3 (2008).}

In their brief, Blue Shield relies on case law from other states that distinguish postclaims underwriting from postclaims investigation.\footnote{57 Brief of Respondent at 19, Hailey v. Cal. Physicians’ Service, 158 Cal. App. 4th 452 (Cal. App. 4th Dist. 2007) (No. G035579) (citing case law from Kentucky, Mississippi, Illinois and Cal. case law predating enactment of 1389.3).} In particular, Blue Shield cites an Illinois case, \textit{Brandt v. Time Ins. Co.} that faced similar questions and concluded that the law “imposes no duty on an insurer to conduct an independent investigation of insurability before issuing an insurance policy.”\footnote{58 Brandt v. Time Ins. Co., 704 N.E.2d 843, 846-47 (Ill. Ct. App. 1998).} The Illinois court held that a plan could properly complete underwriting relying solely on information submitted in an application.\footnote{59 Id.} Blue Shield urges a similar interpretation of underwriting in California, which would support their contention that underwriting was completed, which would make section 1389.3 inapplicable.

In their reply brief, the Haileys note Blue Shield’s reliance on non-controlling case law and argues that Blue Shield’s alleged “postclaims investigation” involved questions of eligibility that should have been resolved during the initial underwriting.\footnote{60 Reply Brief of Appellant-Petitioner at 24, Hailey v. Cal. Physicians’ Service, 158 Cal. App. 4th 452 (Cal. App. 4th Dist. 2007) (No. G035579).} The Haileys also look to the language of the statute requiring plans to “complete medical underwriting and resolve all reasonable questions arising from an application” before issuance.\footnote{61 Id. (emphasis in original).} They suggest that the lack of any medical history for Steve, who was 38-years old and overweight, should have raised a reasonable question to a prudent underwriter. Blue Shield’s failure to resolve this question before policy issuance suggests that the rescission of the policy was postclaims underwriting
within the plain meaning of the statute.\textsuperscript{62} The amicus brief for the Department of Managed Health Care states that health plans routinely claim, as does Blue Shield, that under case law and the Insurance Code they are entitled to investigate applications “after claims are made and rescind contracts based on minor omission or misrepresentations in the application.”\textsuperscript{63} As the enforcement agency tasked with enforcing section 1389.3, the department has received “numerous consumer complaints regarding rescission of individual health care coverage.” The department claims that the plain language and intent of section 1389.3 prohibits exactly the type of activity that Blue Shield engaged in when it rescinded the Haileys’ policy.\textsuperscript{64}

The Court of Appeals recognized the harmful effects of postclaims underwriting in leaving policyholders without coverage at a time when they are most in need. The court proceeds to examine whether, as Blue Shield argues, it is possible to complete medical underwriting by “blindly accepting the responses on a subscriber’s application.”\textsuperscript{65} The court notes that the Illinois case that Blue Shield relies on unfairly allows health care plans to avoid the risks they contracted to undertake. Distinguishing the case, the court recognizes that the Illinois was not faced with a statute specifically designed to “combat postclaims underwriting.”\textsuperscript{66} The court finds that the legislature intended medical underwriting to require “reasonable efforts to ensure a potential subscriber’s application is accurate and complete.”\textsuperscript{67} Looking to the legislative intent and policy reasons underlying the statute, the court extends the “duty of reasonable investigation” from the insurance context to the health care context under section

\textsuperscript{62} Id.
\textsuperscript{64} Id.
\textsuperscript{65} Hailey, 158 Cal. App. 4th at 465-466.
\textsuperscript{66} Id. at 468.
\textsuperscript{67} Id.
Although the court doesn’t point out exactly what steps are required to complete medical underwriting within the meaning of 1389.3, the court holds that the legislature placed a duty to reasonably investigate the accuracy and obtain “all necessary information to accurately assess the risks before issuing the contract.” Having failed to make reasonable efforts to investigate during underwriting, Blue Shield is subject to the limitations of 1389.3.

**B. Willful Misrepresentation Under Section 1389.3**

Although postclaims underwriting is prohibited, the statute contains an exception for fraud. The last sentence of section 1389.3 states that “upon a showing of willful misrepresentation” a plans ability to rescind, cancel or limit a contract is not restricted. Blue Shield claims that even if section 1389.3 applies, “undisputed evidence clearly shows” that the Haileys intended to deceive Blue Shield, implicating the willful misrepresentation exception. This “undisputed evidence” consisted of the original application and Steve’s medical records.

**1. Health Care Service Application**

The four page Blue Shield policy application, as completed by Cindy Hailey, is included in Attachment 1. Part 1 of the application requested general information about the applicant and spouse. On Part 2, which requested information regarding *all covered family members*, Cindy listed information about herself, Steve and her son Scott, including: date of birth, height and weight. On line 2, Cindy listed Steve’s weight as 240, even though it was recorded as 285 during a visit to a hospital the previous month. Cindy’s lawyer, Michael Nutter, stated that since Cindy claimed she thought her husband’s info wasn’t relevant to coverage, the fact she incorrectly stated his weight supports her claim. By the same reasoning, the fact that Cindy

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68 Id. at 471; Barrera v. State Farm Mut. Automobile Ins. Co, 71 Cal.2d 659, 663 (Cal. 1969).
69 Id. at 473.
72 Telephone Interview with Michael Nutter.
was careful enough to correctly list the information for her son’s height and weight, as well as Steve’s work address seems to refute her claim.

Part 3 contains questions relating to the applicants’ medical history. The instructions state: “Have you or any applying family member ever received any professional advice or treatment for or had any symptoms pertaining to any of the following?” (emphasis added). Part 3 continues with thirty questions relating to various symptoms, health conditions and previous treatments. Question 19 asks “Have you or any of your applying family members ever been an inpatient/outpatient in a hospital, surgicenter, sanitarium, or other medical facility?” Although Steve had been to emergency room nine days before, Cindy’s final response is NO. (In the application, it appears Cindy checked the YES box also, but scribbled this response out.) In response to Question 29, which asks “Have your or any applying family seen a physician or health care provider for any reason within the last 60 days?,” Cindy’s final response is NO. (Again, Cindy appears to have checked the YES box, but scribbled out the response.) Questions 19 through 30 all specifically use the language “have you or any applying family member” and the phrase “have you or any applying family member” appears fourteen times in Part 3 alone.

Parts 5, 6 and 7 instruct the applicant to fill out relevant information regarding medical conditions and visits for any family member – Part 5 specifically stating “[b]e sure to identify the family member.” In Part 8, the form conspicuously states above the signature line:

I ALONE AM RESPONSIBLE FOR THE ACCURACY AND COMPLETENESS OF THIS APPLICATION FOR BLUE SHIELD HEALTH COVERAGE . . . I understand that neither I nor my family will be eligible for coverage if any information is false or incomplete, and that coverage may be revoked based on such finding.”

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73 Hailey Application at 2.
74 Hailey Application at 2; Hailey, 158 Cal. App. 4th at 461.
75 Hailey Application at 2.
76 Hailey Application at 2.
77 Hailey Application at 3.
Cindy, Steve and Scott then signed the form – indicating that each was a party to the contract for health coverage. Although Steve claims he didn’t actually read the application before signing, failure to read a contract before signing is not grounds to avoid its terms.  

2. Steve Hailey’s Medical Records

Although the contract authorized a release of Steve’s medical records, Blue Shield did not request the records until a claim had been filed. Once obtain, the records revealed: an emergency room visit on October 29, 2000 – only nine days before the application was signed and submitted; a hiatal hernia, gastroesophageal reflux disease, sleeping problems; a recently recorded body weight of 285 pounds; and a history of hypertension and high blood pressure. Additional discovery conducted in preparation for trial uncovered more health records indicating Steve suffered from chronic and severe headaches, chest and abdominal pains, had undergone surgery for rectal bleeding in 1997, and received a prosthesis as a result of a severe jaw injury. None of these aforementioned conditions were mentioned on the policy application. Blue Shield claims that these extensive medical records along with the omissions in the original application offer conclusive proof of willful misrepresentation.

The court reasoned that Cindy’s explanation – she mistakenly believed the form only required her health information – was “not patently unbelievable.” The court also noted inconsistencies in how the form used the terms “applicant” and “family members” and stated that the application form was “no model of clarity.” Despite the considerable evidence supporting

80 Id.
81 Hailey, 158 Cal. App. 4th at 464.
82 Id.
Blue Shield’s argument, the court still found there was still a triable issue as to whether the Haileys willfully misrepresented Steve’s medical history.

C. Rescission as an Equitable Remedy

Blue Shield further argues that even if the omissions were unintentional errors they are entitled to rescind the contract under the equitable principles of contract law. Under California statute, rescission is an available remedy for all civil contracts, unless superceded by an applicable statute such as section 1389.3. A party may rescind if the consent of the rescinding party was “given by mistake, or obtained through duress, menace, fraud, or undue influence, exercised by or with the connivance” of the other party. The law of rescission effectively restores “both parties to their former position as far as possible” as if the contract had never existed.

Blue Shield’s brief oversimplifies the law of rescission by claiming that “if a party is misled by a material misrepresentation, the misled party is entitled to rescind.” Under Thompson v. Occidental Life, a misrepresentation is material if it would have led the insurer to not enter into the contract; the misrepresentation also needn’t be related to the cause of the medical loss. Although the omissions of Steve’s weight and medical history were not related to the injuries he suffered in the accident, they still constitute material misrepresentations since they were requested on the application and they would have cause Blue Shield to deny the Haileys’

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85 Hailey, 158 Cal. App. 4th at 468.
application for coverage. The amicus briefs supporting Blue Shield also cite Thompson for the contention that “intent to deceive is not required to support rescission.”

Blue Shield and their Amicus Curiae, however, oversimplify and misrepresent the holding of Thompson. Although Thompson does not require intentional misrepresentation in order to rescind a contract, it does require the insurer inquire as to the applicants’ subjective understanding of the application. If the applicant “failed to appreciate the significance of information,” the incorrect responses or omissions are not grounds for rescission. Blue Shield never informed the Haileys of the underwriting investigation and never spoke with Cindy Hailey about the omissions before they concluded it was a misrepresentation and grounds for rescission.

The court does not go into depth on the legality of Blue Shield’s rescission under Thompson or applicable contract law. The court does, however, remark on the inadequacies of the law of rescission in restoring the Haileys to their former position. Not only are the Haileys burdened with medical bills, but Steve’s condition may preclude them from finding adequate health coverage in the future. The court notes it does not intend to alter the law of rescission, but uses these inequities to illustrate the policy arguments underlying section 1389.3’s prohibition of postclaims underwriting. Although the court remains silent on the issue, the limitations on rescission imposed by Thompson in the insurance context, would likely apply to rescissions on health care service plans, making Blue Shield’s rescission unlawful under contract law.

88 Id.
90 Thompson, 9 Cal. 3d at 916.
91 Hailey, 158 Cal. App. 4th at note 6.
D. Intentional Infliction of Emotional Distress

The Haileys’ complaint also alleged that Blue Shield intentionally engaged in extreme and outrageous conduct that caused the Haileys to suffer severe emotional distress. To state a cause of action, the Haileys must allege “extreme and outrageous conduct by the defendant with the intention” to cause emotional distress and the conduct must be the actual and proximate cause of the emotional distress.\(^9^2\) Both the parties and court rely on applicable case law, particularly cases from the insurance context, in their arguments and analysis.

Blue Shield first alleges that a claim for intentional infliction of emotional distress can only be brought if the rescission was wrongful. Blue Shield further claims, that under applicable case law, its conduct cannot be considered extreme or outrageous under case law since it is asserting its legal and contractual right to rescind without notice.\(^9^3\)

The Haileys argue that Blue Shield knew the rescission was unlawful, yet proceeded to rescind the policy and demand payment for past medical services to humiliate and cause emotional distress. By rescinding the contract as soon as Steve was released from the hospital, the Haileys claim that Blue Shield knew Steve might not receive further medical attention and suffer severe emotional distress.

The court reversed the lower court’s ruling on the demurrer, recognizing a cause of action for intentional infliction of emotional distress. Having already ruled that Blue Shield had engaged in unlawful postclaims underwriting, the court could have analyzed the outrageous conduct requirement with this in mind. Instead, the court broadens the application of this cause of action to include even lawful acts of health service plans when asserted in an “outrageous manner.” The court recognizes that a health care plan does not typically subject itself to liability

\(^9^2\) Hailey, 158 Cal. App. 4th at 474-475.
by a good faith attempt to rescind a policy, even if the provider knows it could cause emotional distress. However, Blue Shield’s “wait and see” approach – rescinding the policy only after Steve incurred substantial medical bills – combined with their flagrant disregard of the consequences of rescission on Steve’s medical condition is sufficient to allege “extreme and outrageous conduct.” The court also noted a special relationship between policy providers and policyholders the abuse of which could constitute a cause of action for intentional infliction of emotional distress.

E. Recent Developments in the Hailey Case

After the reversal of the lower court’s grant of summary judgment and demurrer, the Hailey’s continued to pursue their claims against Blue Shield and in May of 2009 went to trial in Orange County Superior Court. In mid-trial, however, the court granted a motion for a directed verdict by Blue Shield that the Haileys and Blue Shield had come to an agreement and that Blue Shield had acted properly in rescinding the health care plan. The Haileys submitted a joint stipulation of factual and legal issues that included assertions that Blue Shield’s underwriting had made “reasonable efforts;” Blue Shield “acted in good faith;” the rescission investigation was reasonable and timely; the Haileys “willfully misrepresented and willfully omitted material information” on their application; the application was “clear and unambiguous;” “Blue Shield did not breach its contract;” and “Blue Shield did not commit post-claims underwriting.” Surprisingly, the joint stipulation came one day after the Hailey’s expert witness had testified that the application was “highly ambiguous and confusing and that Blue Shield had not done

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94 Hailey, 158 Cal. App. 4th at 476.
95 Id.
sufficient underwriting.”99 After the ruling, Blue Shield dropped a countersuit against the Haileys and waived all court costs and fees. Nothing in the court records indicate what led the Haileys to suddenly change their minds and make the stipulations and there was no settlement reached between the parties. While Blue Shield has been quick to claim victory and disregard the precedential effect of the Court of Appeals decision, critics counter that the case was not heard on the merits and was actually a settlement because the Hailey’s stipulation likely resulted from an undisclosed exchange.100 The only other similar case to go to trial, a suit against Health Net Inc., resulted in a $9 million verdict against the policy provider for a bad faith rescission.101 Blue Shield’s eagerness to claim victory suggests Blue Shield avoided making a public settlement in such a high profile case and was seeking to reverse the damage caused by the Court of Appeals decision. When asked if Blue Shield offered money or incentives to submit the stipulation, the Haileys and their attorney had no comment.102 At least one critic, William Shernoff, an attorney representing similarly situated policyholders, has called for an State Bar investigation to determine if there had been an exchange or undisclosed settlement.103 Regardless of the outcome of the Hailey’s trial, Shernoff said that the directed verdict would have no effect on future cases and that “[t]he appellate court opinion is the law.”104

101 Girion, supra note 98, at 2.
102 George, supra note 99.
103 George, supra note 99.
104 Id.
IV. UNDERLYING PUBLIC POLICY ARGUMENTS

A. Health Care in California

The U.S. health care industry is often referred to as an industry in crisis.\(^ {105}\) The high number of uninsured, rising costs of prescription drugs and medical services, burdensome restrictions on health care service plan coverage and substandard quality of care all contribute to this perceived crisis.\(^ {106}\)

1. Development of Health Care in California

The health care service industry, which evolved from health insurance, adopted many of the same regulations that continue to govern insurance contracts. Many of the same goals and policy arguments underlie both health insurance and health care service plans. The first health insurance, covering illness and disability, formed in the late 1890’s.\(^ {107}\) In the 1930’s, through the sponsorship of employers, modern group health insurance plans began to form. Two non-profit organizations, Blue Cross and Blue Shield, organized extensive health insurance plans, which they sold to employers across the country.\(^ {108}\) Blue Cross and Blue Shield negotiated discounts with doctors and hospitals in exchange for directing policyholders to their medical services. As the need for health care plans increased, each state began to establish Blue Cross and Blue Shield organizations. Founded as a non-profit by the California Medical Association in 1938, Blue Shield of California offered group health coverage plans to California employers, and in 1949, began offering separate individual and family health plans.\(^ {109}\)

Along with the Medi-Cal reforms in the early 1970’s, an increase in costs and demand for health care led to widespread use of health maintenance organizations (HMOs), an early form of


\(^{106}\) Id.


\(^{109}\) Blue Shield of California was created as California Physician’s Service, doing business as Blue Shield of California History of Blue Shield, https://www.blueshieldca.com/bsc/aboutbsc/history/index.jhtml.
pre-paid health care service plans. Health care service plans lowered costs by contracting within a network of doctors and hospitals, eliminating unnecessary services and requiring referrals from a primary care physician.\textsuperscript{110} Even though these plans were primarily non-profit, mismanagement and misappropriation led to fraud and denial of necessary medical care. As a result, the California State Legislature passed the Knox-Keene Act specifically to license and regulate health care service plans. Although many Blue Cross and Blue Shield entities have converted to for-profit entities, Blue Shield of California continues to operate as a non-profit,\textsuperscript{111} currently providing coverage for over 3.2 million people across the state of California.\textsuperscript{112}

As costs for health care and medical procedure have increased, health care plans have taken actions to increase efficiency and remain competitive. One tactic has been to convert to for-profit entities and raise money through sales of shares in company stock. While some commentators argue for-profit plans provide a decreased quality of care, companies claim that the move toward profit does not compromise their policies or commitment to quality health care.\textsuperscript{113} Over the past few decades, the trend of health care service plans has been a move toward for-profit conversion.\textsuperscript{114} In 1980, ten of the twelve health care services plans licensed under California’s Knox-Keene Act were non-profit. Today, California is dominated by five health care service plans, and only two, Kaiser and Blue Shield of California, are non-profit.\textsuperscript{115}

Another tactic to increase efficiency and keep premiums low has been to 1) lower the risk tolerance of health care service plans and 2) reduce fraud through postclaims investigations.

\textsuperscript{114} \textit{Id}.
Although reducing risk tolerance by assuming less risk decreases the number of claims, also known as medical losses, this practice also denies more applicants. As health care costs rise, employer sponsored group coverage has declined, forcing more and more people to seek individual coverage. A 2005 study showed that approximately 11.8% of individual health care policy applicants were denied for medical reasons.\textsuperscript{116} As denials and high-risk premiums rise, the number of applicants that commit fraud or misrepresent their risks to obtain affordable coverage also rises. Plan providers argue that postclaims investigations are an important tool in identifying and preventing applicant fraud. Blue Shield insists that to stay in business they must exclude chronic disease sufferers, known as “clinical train wrecks.”\textsuperscript{117} This statement seems to suggest that a plan’s reliance on \textit{postclaims investigations} may be less about combating fraud and more about avoiding costly medical losses. While commentators often point to profit motives as justification for this practice, Blue Shield’s non-profit status may suggest that plan providers actually have a good faith belief in the use of postclaims investigations as a way to increase efficiency and ensure quality care. Regardless of their intent, policies such as these make it easy to see why people commonly lament that “health insurance is only for the healthy.”\textsuperscript{118}

2. Necessity of Postclaims Investigations

From the health care service plans’ perspective, it is understandable why postclaims underwriting – what Blue Shield refers to as postclaims investigations – has become so widespread. By only investigating policyholders that file substantial claims, insurers and policy


\textsuperscript{118} http://www.wellsphere.com/cancer-article/health-insurance-coverage-only-for-the-healthy/194404.
providers can prevent and recover medical losses with a minimal use of resources. As postclaims underwriting has come under increased scrutiny, health care organizations have responded in different ways. In 2007, Blue Cross of California agreed to a class-action settlement regarding unlawful rescissions and agreed to change its underwriting policies.\textsuperscript{119} Blue Shield of California, however, continued to defend its use of postclaims investigations in court with mixed results.\textsuperscript{120} The \textit{Hailey} decision, however, finally seems to foreclose Blue Shield’s arguments that its postclaims investigations are not prohibited as postclaims underwriting under section 1389.3.

Another way in which plan providers increase efficiency is to claim that material misrepresentations justify policy rescission under contract law. It is well established in insurance law that if an application requests information about a particular condition then it is material.\textsuperscript{121} By including benign conditions such as athlete’s foot or yeast infections, an insurer or plan provider can claim the condition is material to eligibility decisions. If the provider can later show the condition was omitted from the application, this may constitute a material misrepresentation. This practice makes rescission possible in cases where the misrepresentation involves something as inconsequential as a yeast infection. This also suggests that some plans have reduced their level of risk tolerance to unreasonably low levels. Some applicants have been denied coverage simply because they had listed “hay fever, jock itch or use of common medicines.”\textsuperscript{122}

Although the prohibition of postclaims underwriting was incorporated into the code in 1993, the statute was not routinely enforced by the Department of Managed Health Care until

\textsuperscript{119} Victoria Colliver, Facing Suits, Health Insurers Take Different Tacks (June 2, 2007), http://www.sfgate.com/cgi-bin/article.cgi?file=/c/a/2007/06/02/BUGBH39801.DTL.
\textsuperscript{120} Id.
\textsuperscript{121} Thompson, 9 Cal. 3d at 916.
\textsuperscript{122} Id.
2006. Despite the plain language of the statute, Blue Shield and other plan providers resisted the department’s attempts to regulate postclaims underwriting.

Although not discussed by the court, Blue Shield’s interpretation of section 1389.3 is completely incompatible with the purpose of the statute. Although Blue Shield claims that the Department of Managed Health Care’s interpretation of section 1389.3 would preclude the possibility of postclaims investigations, in fact, Blue Shield’s interpretation of medical underwriting precludes the possibility of postclaims underwriting. If simply accepting an application constituted completion of proper underwriting, then postclaims underwriting would never occur. It would be hard to imagine a situation in which a provider investigates a covered policyholder but has never received an application for coverage. Since every covered individual policyholder has necessarily submitted an application, under Blue Shield’s interpretation, any subsequent investigation could never be considered postclaims underwriting.

Health service plans commonly underestimate the harmful effects of rescission from postclaims underwriting. The California Association of Health Plans states that postclaims investigations typically result in rescission in less than 0.001 percent of new policies. While this figure attempts to portray rescission as an almost insignificant problem, because nearly 3 million Californians rely on individual health insurance plans, 0.001 percent actually equates to roughly 3,000 Californians. Although fewer Californians apply in a single year, the enormity of California’s insurance pools demonstrates that even 0.001 percent is not insignificant. Plan providers relying on postclaims investigations argue that the practice predominately targets flagrant fraud and abuse. This suggests that cases where rescission occurred after minor or

\[\text{See } \text{www hmohelp ca gov/library/reports/med_survey/surveys/303full032307.pdf and www hmohelp ca gov/library/enforcements/noteworthy/25438.pdf.}\]


\[\text{Id.}\]
unintentional mistakes are the exception, implying that those people must have slipped through the cracks. As one former health plan employee tasked postclaims investigations stated, “[These people] are not slipping through the cracks, somebody made that crack and swept [them] toward it.” 126 This calls into question Blue Shield’s claim that they are entitled to rely on the information in an application. It appears Blue Shield does not rely on the application to properly assess risks, but relies on the application to avoid costly risks through postclaims investigations.

Blue Shield and other plans commonly cite concern for the policyholders’ welfare and the solvency of the system as justification to investigate potential fraud. 127 However, net income and profits of insurer and plan providers, both non-profit and for-profit, respectively, have risen sharply in recent years. In 2005 alone, according to the California Health Care Foundation, profits for health plans increased from $640 million in 1996 to $2.7 billion in 2005. 128 This seems to call into question the necessity of postclaims investigations in countering the problem of fraud to ensure solvency of the system and quality of care. In retrospect, it seems that if maintaining the viability and quality of care requires rescinding or denying coverage at the first appearance of misrepresentation, perhaps there is no viability or quality of care to maintain.

126 Lee Einer, former health care company investigator (as interviewed in Moore’s Sicko Documentary on U.S. Health Care); see also Lee Einer, Article: Faux Health Insurance for the Self-Employed: The Sham, The Scam, The Shame of It, Honest Medicine, August 28, 2007, available at http://www.honestmedicine.com/2007/08/sicko-hitman-le.html (Although Mr. Einer is a controversial figure appearing in a controversial documentary, his interview offers an interesting insight into the operations of major policy providers once a claim is filed.); But see Memorandum from Barclay Fitzpatrick, VP of Corporate Communications for Capital BlueCross (July 3, 2007), available at http://www.michaelmoore.com/_images/splash/Capital_BlueCross_sicko.pdf (responding to the points raised in Moore’s Sicko documentary, including Lee Einer’s interview, as applied to Blue Cross and Blue Shield).
B. Fallout of *Hailey* Decision on Enforcement of Section 1389.3

1. Immediate Effects

   In response to the clarified standard for medical underwriting under section 1389.3 under *Hailey*, the Department of Managed Health Care ordered independent reviews of every rescission or policy cancellation from the previous four years.\(^{129}\) The department continues its investigations into the five largest policy providers’ rescission practices.\(^{130}\) As a result, so far, Kaiser Permanent is reinstating coverage for 1,092 consumers whose policies were canceled or rescinded from 2004 to 2006 and must pay a $300,000 fine. Similarly, Health Net reinstated 85 consumers. In April 2008, the department was investigating 180 consumers whose policies were rescinded by Blue Shield as well as an estimated 4,000 under other policy providers.

   In 2008, the California Department of Managed Health Care brought suit against Blue Shield alleging postclaims underwriting and improper rescissions of individual health plan coverage.\(^{131}\) Blue Shield agreed to pay $12.6 million in fines, reinstate 700 improperly rescinded policies, and compensate members for medical expenses caused by the rescissions.\(^{132}\) The company also stated that it planned to enact new underwriting procedures in light of its clarified responsibility and duties to its customers.\(^{133}\) Although Blue Shield and other plan providers resisted the Department of Managed Health Care’s attempt to enforce section 1389.3, it appears that the *Hailey* decision has finally clarified the health care service plan’s responsibilities toward its customers and its duty to investigate during underwriting.


\(^{132}\) Id.

\(^{133}\) Id.
Legislators also continue to counter the harmful practice of postclaims underwriting through additional regulations in the Insurance Code and the Health and Safety Code. On July 22, 2007, Governor Arnold signed into law Bill AB 1150, citing the “urgent need to protect consumers from unfair health care rescissions.” The bill prohibits both health care service plan providers and health insurance providers from compensating employees that review underwriting decisions based on the number of policies rescinded or costs saved by rescinding, canceling or limiting policies. Given the substantial influence of the California market on the national health care industry, other states will likely follow suit enacting legislation putting limits on postclaims underwriting while further regulating and improving the process of medical underwriting. The increased focus on the harmful practice of rescinding policies based on innocent misrepresentations may also result in federal legislation. U.S. Representative Henry Waxman of California conducted a U.S. Congressional hearing on the impact of postclaims underwriting and plans an oversight committee to investigate the issue on a national level.

2. Potential Impact

Although the Hailey decision has already had widespread effect on the rescission policies of health care service plans, the impact will likely continue to improve the policies of health care service plans and contribute to the state and national debate on health care reform. While recognizing a plan’s duty to reasonably investigate during underwriting, the Court of Appeals noted that it did not specifically define the requirement for underwriting. The duty to investigate is a more flexible standard that health care plans will likely find more difficult to avoid.

135 Id.
There are still questions, however, as to the scope of a plan’s duty to investigate. At a minimum, the court stated that simply relying solely on the information supplied in an application did not satisfy the duty to reasonable investigate question raised from medical underwriting. Blue Shield claims that a duty to investigate during medical underwriting would require a provider to investigate “every answer by every applicant,” slowing issuance of coverage and greatly increasing the costs of underwriting.\(^{137}\) What Blue Shield fails to appreciate, however, is that even if costs of underwriting rise, increasing the accuracy of risk assessment will result in less fraud, increased efficiency and additional cost savings. Furthermore, Blue Shield exaggerates the difficulties in conducting a reasonable investigation in medical underwriting. In recent years, HIPAA and the widespread use of electronic, online databases have simplified access to medical records.\(^{138}\) Additionally, companies, such a MIB Solutions, specialize in providing extensive medical records to aid insurers and plan providers in medical underwriting; MIB claims that use of their databases has increased 14 percent within the first six months of 2007.\(^{139}\) Furthermore, Blue Shield’s ability to quickly discover Steve’s omissions by obtaining his medical records after a claim was filed undercut Blue Shield’s argument that investigation is inherently time consuming and expensive.

If, as Blue Shield claims, reasonable investigations were prohibitively expensive and implausible, then section 1389.3 would effectively act as a strict liability rule preventing rescission after policy issuance. Rescission would be prohibited in all but the most blatant instances of willful misrepresentation. Even if this were the case, this strict liability rule would not be inappropriate and would rightfully transfer the risks associated with medical care to the party most able to bear that burden. Additionally, it seems the insurer or plan provider is far

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\(^{139}\) MIB Solutions News Release (June 20, 2007) (on file with author).
more knowledgeable and capable to obtain the necessary medical information to properly assess risks. Plan providers employ risk specialists and doctors that are far more likely than a consumer to identify and understand symptoms, conditions, confusing medical language. It would seem that to be certain that medical underwriting was completed a plan provider would have to make a good faith search for all a patient’s medical records, obtain and perform a cursory examination of the records and discuss any reasonable questions with both the consumer and, if appropriate, their physician. Given the availability of electronic information, faxes and telephones, it seems that this duty is entirely reasonable to require. In complying with this duty, plan providers might also find the benefits of increased accuracy outweigh the costs of investigation.

The *Hailey* decision may also shed light on the growing problem of the uninsured in California. Although not mentioned in Blue Shield’s briefs, rescission and reduction of risks negatively impact the costs and efficiency of health care service plans. Those whose coverage is rescinded may be unable to pay physician or hospital bills, which in turn, increases the overall costs of medical care. The costs of medical care for the uninsured are typically passed on to governmental or public entities. These problems raise the cost of hospitalization and medical procedures leading to higher premiums for both group and individual policies. The New America foundation found that this effect has raised premiums by approximately 10% for both types of policies.\(^{140}\) One solution to this problem involves a mandate that all Californians have some type of medical coverage. This forces low risk consumers into the system and covers those in most need of health coverage. On January 8, 2007, Governor Schwarzenegger proposed a state plan

\(^{140}\) *Id* at 2-3.
requiring all individuals be covered by a health care policy, requiring insurers and policy providers to guarantee coverage.\textsuperscript{141}

V. CONCLUSION

In summary, the U.S. health care industry is undergoing a gradual change and beginning to address the problems associated with post-claims underwriting. Although only a minority of states have prohibited the practice and enforcement of existing statutes has been inconsistent, recent cases have put nationwide attention on post-claims processing. These changes can be seen in the recent California case, \textit{Hailey v. California Physicians Service}, and its effects on the California’s statute prohibiting post-claims processing, section 1389.3. This decision has had a ripple effect throughout the California health care industry. First, the decision has provided a longer over-due clarification of section 1389.3’s prohibition of postclaims underwriting. The court’s holding flatly rejects Blue Shield’s use of so-called postclaims investigations to rescind health care policies, and imposes a duty to investigate all reasonable questions arising from the application of a health care policy. The court has brought the requirements for medical underwriting into greater alignment with the underwriting standards of insurance, while recognizing the underlying policy issues that justify a heightened standard for medical underwriting. The court expands on the harm that postclaims underwriting causes in denying consumers health coverage at a time when it is needed most. The court’s decision regarding section 1389.3 addresses public policy concerns, but is based primarily on the plain language and legislative intent of the statute. The impact of the \textit{Hailey} decision was felt almost immediately. The Department of Managed Health Care launched extensive investigations into the major health plans rescission practices finding hundreds of cases of unlawful postclaims underwriting. Blue

Shield and other health plans that had resisted regulation under section 1389.3 for years, have finally begun to enter into settlements, restore unlawfully rescinded policies and pay for the damages caused by the rescission.

Ultimately, the *Hailey* decision is only one example of a widespread trend of policyholders combating the practice of postclaims underwriting. The *Hailey* decision provides guidance for other states interpretations of similar statutes. The *Hailey* is only one of many cases across the country that have successfully brought attention to the problem of post-claim underwriting and questionable rescission practices. Congress’ recent hearings on these issues have put increasing pressure on plan providers to abandon the practice and reinforced attempts by state health departments to enforce existing regulations. By continuing to regulate prohibit post-claims underwriting and renew enforcement efforts, states will further the legislative intent of the Knox-Keene Act – to deliver “quality medical care to the people of the State of California” in a “manner providing continuity of care” and to transfer “the financial risk of health care from patients to providers.”

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142 Cal. Civil Code § 1342 (d), (g) (2008).