FEATURE ARTICLE

California Supreme Court Denies Review of Post-Claims Underwriting Case: *Health Plans Must Conduct Pre-Issuance Investigation or Show Enrollee Deception Before Canceling Policies*

By William L. Abalona and Nathaniel M. Lacktman

INTRODUCTION

In the first published opinion on the application of Health and Safety Code section 1389.3 (prohibiting post-claims underwriting), the California Court of Appeal held that California Physicians' Service d/b/a Blue Shield of California ("Blue Shield") violated the statute by denying coverage retroactively when it should have obtained the necessary information and made its decision as part of the pre-contract underwriting process.[1] Practices by several health plans described as "post-claims underwriting" have given rise to complaints brought by policyholders who contend their coverage was wrongfully denied.[2] The California Department of Managed Health Care ("DMHC") has also taken action on the issue.[3]

On its face, the *Hailey* decision appears to require health plans to conduct a reasonable medical investigation on an applicant, prior to issuing a policy. A health plan that fails to do so may be barred from later rescinding the policy, absent willful misrepresentation by the applicant. On March 26, 2008, the California Supreme Court denied review, effectively making *Hailey* state law.

BACKGROUND FACTS

The Application Process

Blue Shield is a health care service plan licensed and regulated by the DMHC. At the time relevant to the events leading up to this case, the Appellate Court decision recites that Blue Shield had in place the following policies and procedures regarding coverage: to obtain coverage under a Blue Shield contract, applicants must qualify based on their medical and health history and complete an application requesting specific medical history information. In signing the application, the applicant attests to the accuracy and completeness of the responses, and acknowledges the plan may revoke coverage if the applicant furnishes false or incomplete information.

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1 *Hailey v. California Physicians' Service, d/b/a Blue Shield of California*, 158 Cal. App. 4th 452 (4th Dist., Div. 3) (December 24, 2007), *petition for Supreme Court review denied* March 26, 2008.

2 *California v. Health Net Inc.* Cal. Sup. Ct., No. BC385816 (filed February 20, 2008) (City Attorney's office charged health plan with illegal termination of coverage and false advertising); *In the Matter of Arbitration between Bates v. Health Net Inc.*, Case No. BC321432 (February 21, 2008) (arbitration award of $9.3 million for health plan's bad faith rescission of plaintiff's coverage).

3 "California Fines Blue Cross $1 Million for Illegally Cancelling Coverage," *BNA Health Care Daily Report*, Vol. 12, No. 57 (March 26, 2007); "California Regulators Want Blue Shield to Pay $12.6 Million for Rescinding Health Coverage," *BNA Health Care Daily Report*, Vol. 12, No. 240 (December 14, 2007).

Blue Shield then evaluates the application by assigning a point value to the applicant's past and current medical history and conditions. Some conditions are sufficient by themselves to warrant denial of coverage, while others may prompt a postponement in the process to allow Blue Shield to obtain additional information. Based on the point values, Blue Shield grants coverage, grants coverage at an increased rate, or denies coverage.

STEVE AND CINDY HAILEY

Plaintiff Cindy Hailey submitted an application for family health insurance to Blue Shield. As described in the Court's opinion, Ms. Hailey believed she provided all the requested information on the application. However, she mistakenly believed the form sought information relating to her health alone, and not that of her husband, Steve Hailey, or their son, even though the coverage was for the entire family. She included her own health history but omitted any health information regarding her husband and son.

Ms. Hailey sent the completed application to Blue Shield, which, after receiving it, asked her additional questions regarding her health history, but did not go over any of the application's questions. Blue Shield extended coverage to Cindy and her family beginning December 15, 2000.

Two months later, Mr. Hailey was admitted to the hospital for stomach problems. Based on that claim, Blue Shield's Medical Management Department referred the Haileys' contract to its Underwriting Investigation Unit for investigation of possible fraud in the application for coverage. In its probe, Blue Shield obtained Mr. Hailey's medical records, which revealed a history of health issues not disclosed on the application.

One month later, an automobile accident left Mr. Hailey permanently disabled. He remained hospitalized two months before he was released home with instructions for additional home nursing care and physical therapy. Before his discharge, Blue Shield authorized healthcare providers to provide surgery, treatment, care, and physical therapy in an amount exceeding $457,000.

The next month, Blue Shield informed the Haileys that it had cancelled their coverage retroactively to December 15, 2000, the date Blue Shield issued the policy. Blue Shield based its cancellation on the Haileys' failure to disclose medical information regarding Mr. Hailey's health history. Blue Shield requested the Haileys pay $60,777.10, the difference between the amount Blue Shield paid for Mr. Hailey's medical care, and the premiums the Haileys paid for the insurance coverage.

After Blue Shield cancelled the policy, the Haileys could no longer afford nursing care or physical therapy for Mr. Hailey. Third party medical providers demanded the Haileys pay for medical care previously provided. Because of the delays in obtaining necessary medical care and physical therapy, Mr. Hailey's bladder ceased to function, his ability to walk was impaired, and he required further surgery and medication.

THE LAWSUIT

The Haileys sued Blue Shield, alleging breach of contract, breach of the implied covenant of good faith and fair dealing, and intentional infliction of emotional distress. The trial court sustained Blue Shield's demurrer to the intentional infliction of emotional distress cause of action. Blue Shield filed a cross-complaint seeking a declaration that it legally rescinded its health care contract and was entitled to recover the money it spent on Mr. Hailey's medical care. Blue Shield then filed a motion for summary judgment against the Hailey's complaint.

The trial court granted Blue Shield's summary judgment motion, determining that the Haileys' misrepresentations and omissions on the application justified rescission, and entered judgment for Blue Shield on its cross-complaint in the amount of approximately $100,000.[4] The Haileys appealed.

THE COURT OF APPEAL'S RULING

The Court of Appeal reversed the trial court's judgment, holding that a health plan seeking to rescind an enrollee's coverage first must demonstrate that a misrepresentation or omission on the application was willful, or show that the plan made reasonable efforts to ensure the information on the application was accurate and complete before

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4 *Hailey, supra,* 158 Cal. App. 4th at 462.

issuing the contract.[5] To prevent health plans from shifting the financial risk of health care onto enrollees, the Legislature in 1993 enacted Health & Safety Code section 1389.3, which provides:

> No health care service plan shall engage in the practice of post-claims underwriting. For purposes of this section, 'post-claims 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 Court of Appeal found a health plan cannot wait until a claim has been filed to obtain information and make underwriting decisions which should have been made when the application was submitted, not after the policy was issued.[6] Its ruling marked the first appellate level opinion on the scope of Section 1389.3.

The Court of Appeal stated the harm from post-claims underwriting is manifest.[7] It recognized a health plan's obligation to its enrollees to perform underwriting at the time a policy application is made, not after a claim is filed. It is patently unfair, the Court of Appeal reasoned, to allow a claimant to obtain a policy, pay his premiums and operate under the assumption that he is insured against a specified risk, only to learn ***after*** he submits a claim he is not insured. If the insured is not an acceptable risk, the Court of Appeal noted, the application should be denied up front, not after a policy is issued. This allows the proposed insured to seek other coverage with another company before becoming seriously ill or suffering a significant injury, as few, if any, health plans will insure an individual who has suffered serious illness or injury, the Court of Appeal found.

Focusing on the last sentence of the statute, the Court of Appeal determined the Haileys raised a triable issue of fact whether or not the misrepresentations on the application were willful. The Court of Appeal rejected Blue Shield's argument that Section 1389.3's prohibition on post-claims underwriting does not affect its right to perform a post-claims investigation.

The Court of Appeal also acknowledged the difficulty of drawing a distinction between post-claim eligibility investigation and post-claim underwriting.[8] Both involve a common activity: research into a subscriber's pre-contract health after a claim is made to determine whether to rescind the plan due to misrepresentations or omissions in the original application. The distinction between post-claims investigation and post-claims underwriting lies in the quality of the underwriting process undertaken before the policy is issued.

According to the Court of Appeal, Blue Shield had a duty under Section 1389.3 to make reasonable efforts, as part of the pre-contract underwriting process, to ensure the Haileys' application was accurate and complete. Given the likelihood of inadvertent error, accurate risk assessment requires a reasonable check on the information the insurer uses to evaluate the risk. A plan cannot "complete medical underwriting" within the meaning of Section 1389.3 by blindly accepting the responses on a subscriber's application without performing any inquiry into whether the responses were the result of mistake or inadvertence.[9] The Court of Appeal noted:

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5 *Id.* at 459-460.

6 *Id.*

7 *Id.* at 465-466.

8 *Id.* at 466.

> [I]n order to effectuate Section 1389.3's purpose, and in light of the equitable nature of rescission, we interpret "medical underwriting" to require a plan to make reasonable efforts to ensure a potential subscriber's application is accurate and complete. Because the circumstances of each case vary, we do not precisely spell out what steps constitute a reasonable investigation. This will usually present a question of fact.[10]

Based on its interpretation of Section 1389.3, the Court of Appeal reversed the trial court's summary judgment ruling. The Court of Appeal also concluded that a triable issue of fact existed whether Blue Shield engaged in bad faith, and that the Haileys adequately alleged a cause of action for intentional infliction of emotional distress.[11]

REACTION TO RULING

While answering some questions, the decision raised others. What happens if a plan later learns of information that was not revealed during a reasonable investigation? What if a plan conducts a detailed investigation after issuing the policy but before medical treatment is provided? It is not clear whether these scenarios would permit a health plan to rescind the policy after issuance or terminate the contract before the contract period ends. As a practical matter, the decision may result in plans requiring far more detail in the application process. It also may result in plans delaying or limiting access to coverage due to the insurance company's increased risk.

For years, health plans in California have rescinded policies, "citing misrepresentations or omissions that the plans discovered, generally after reviewing applications of enrollees who filed large claims for treatment."[12] The DMHC endorsed the *Hailey* ruling, noting that the decision "supports the DMHC position that health plans have the obligation to conduct the proper medical underwriting upfront."[13]

The ruling follows a wave of criticism against the practice of post-claims underwriting. On March 23, 2007, the DMHC fined Blue Cross $1 million following a survey of its post-claims underwriting practices.[14] The survey was conducted to evaluate Blue Cross's compliance with Section 1389.3 and the DMHC is conducting a second survey. On April 17, 2008, the DMHC ordered Blue Cross and two other health plans to immediately reinstate coverage for 26 consumers whose insurance policies were wrongfully rescinded.[15] The Department of Insurance has joined the DMHC to eliminate post-claims underwriting and seeks over $12 million in fines against Blue Shield for its policy rescission and claims processing practices.[16] Blue Shield has indicated it will challenge the fines.

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9 *Id.* at 469.

10 *Id.* at 469.

11 *Id.* at 472-478.

12 "Health Plans Must Show Enrollee Deception Before They Can Cancel Policies, Court Rules," *BNA Health Care Daily Report*, Vol. 12, No. 247 (December 27, 2007).

13 *Id.*

14 "Final Report, Non-Routine Medical Survey of Blue Cross of California, A Full Service Health Plan," California Department of Managed Health Care (March 23, 2007) *available at* www.dmhc.ca.gov/library/reports/med_survey/surveys/303full032307.pdf.

15 "DMHC Reinstates Coverage for Consumers Wrongfully Rescinded by Health Plans," California Department of Managed Health Care (April 17, 2008) *available at* www.hmohelp.ca.gov/library/reports/news/prrescissionreinstatement.pdf.

16 "California Regulators Want Blue Shield to Pay $12.6 Million for Rescinding Health Coverage," *BNA Health Care Daily Report*, Vol. 12, No. 240 (December 14, 2007).

The DMHC is reviewing draft regulations, issued in October 2007 to clarify questions of policy rescissions, to determine if the regulations are consistent with the *Hailey* ruling.[17] The DMHC has combined its efforts with the Department of Insurance to use the regulations as an opportunity to provide more specific guidance on what constitutes "reasonable efforts" of review for medical underwriting.[18]

IMPACT ON PROVIDERS

Although the decision appears to hold a health plan would be advised to conduct a reasonable investigation into an applicant's medical history before issuing a policy, the Court of Appeal did not describe what constitutes a reasonable investigation. The decision might be read to require plans make a final decision on whether to extend coverage as part of the pre-contract process that can only be overturned by a showing of willful misrepresentation. But it also could be read to allow a later, more detailed investigation after the policy is issued and for the policy to be rescinded prior to any claims being made.

To the extent the *Hailey* ruling reduces the number of patients who unexpectedly find their claims retroactively not covered, it could offer greater financial security for providers. If a health plan denies coverage after a provider has treated a patient, the provider would need to look to the patient for payment. Often, patients lack the resources to cover those expenses (the reason they have health insurance in the first place). Because the *Hailey* ruling imposes a greater affirmative obligation on health plans to perform screening prior to issuing a policy, providers should have greater assurance that payments for covered patients will not be retroactively denied. Conversely, the *Hailey* decision also may decrease the number of patients with timely access to health insurance coverage, as health care service plans and insurance companies may be more reluctant to issue policies quickly prior to performing a thorough investigation.

CONCLUSION

The Court's decision in *Hailey* is consistent with the recent regulatory posture of the DMHC to regard retroactive denial of coverage as a likely Section 1389.3 violation. Yet, questions remain as to how plans might retroactively deny coverage without implicating the statute. If Ms. Hailey's application omissions are found to be intentional, there seems little doubt that the subsequent denial of coverage will not be judged retroactive underwriting. But *Hailey* leaves open the question of what constitutes a "reasonable investigation" of coverage at the time the policy is initially issued. With no clear standards of what may be "reasonable," it is an issue of fact determined at the trial court level. It also is unclear how to distinguish between a permissible post-claim eligibility investigation and an impermissible post-claim underwriting investigation. Although the decision raises as many questions as it answers, it marks a significant step toward judicial enforcement of the prohibition on post-claims underwriting. Legal counsel to health plans and providers are advised to monitor the DMHC's reaction to the decision and look for the forthcoming regulations.

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17 Draft text of 28 CCR § 1300.89.3 ("Medical Underwriting; Prohibition of Post Claims Underwriting") (October 22, 2007) *available at* www.dmhc.ca.gov/library/reports/news/pcuregsd.pdf.

18 "Insurance Commissioner Poizner Joins DMHC in Battle Against Rescissions," *Dept. of Insurance Press Release* (October 23, 2007) *available at* www.insurance.ca.gov/0400-news/0100-press-releases/0060-2007/release102-07.cfm.

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