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Why the Rescission of Health Insurance Policies is Not an Equitable Remedy

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WHY THE RESCISSION OF HEALTH INSURANCE POLICIES IS NOT AN "EQUITABLE" REMEDY

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INTRODUCTION

Since 2004 the practice of rescinding and cancelling insurance policies has garnered national and congressional attention. Indeed, one important objective of the recently passed health reform legislation was to put legal limits on insurers' use of rescission. Based in contract law, rescission is an equitable remedy that allows a contracting party to, after the discovery of a material misrepresentation, retroactively cancel all promises.[1] The remedy is intended to restore parties to their status quo.[2] In the context of health insurance, an insurer can usually rescind an insured's policy if any material misrepresentation is discovered in an insured's insurance application.[3]

The health insurance industry's use of rescission first drew attention in California. In 2006, California's state insurance commissioner initiated an investigation into claims that Blue Cross had a system in place to intentionally and illegally rescind policies.[4] Though a majority of the litigation and publicity on this issue comes from California, statistics show that rescissions are not isolated to California.[5] An investigation by the House Subcommittee on Oversight and Investigations showed that health insurers WellPoint Inc., UnitedHealth Group, and Assurant Inc. cancelled the policies of more than 20,000 people and avoided paying more than three million dollars over a five-year period.[6] What is more troubling is evidence that insurers provided financial incentives to employees who successfully rescinded policies.[7] When questioned about these practices, insurance executives refused in the absence of mandatory laws or health reform to limit rescissions to cases of clear and intentional fraud.[8]

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1. *See infra* Part I.B.

2. *Id.*

3. *See infra* note 48.

4. Lisa Girion, *Garamendi to Probe Blue Cross' Practices*, L.A. TIMES, Mar. 30, 2006, at C1.

5. A survey of fifty-two insurance companies conducted by the National Association of Insurance Commissioners uncovered that between 2004 and 2008 27,246 health insurance policies were rescinded. Based on the sample size of the study, this number of recessions translated into a rate of 3.7 rescissions for every 1,000 policies in force. NAT'L ASS'N OF INS. COMM'RS, RESCISSION DATA CALL OF THE NAIC REGULATORY FRAMEWORK (B) TASK FORCE 1 (2009), http://www.insurance.illinois.gov/hiric/RescissionDataCall.pdf (last visited Nov. 16, 2010). The survey also determined the number of rescissions per state per 1,000 issued policies. New Mexico topped the list, with over eighteen rescissions for every 1,000 policies issued. *Id.* at 7.

6. Lisa Girion, *Blue Cross Praised Employees Who Dropped Sick Policyholders, Lawmaker Says*, L.A. TIMES, June 17, 2009, at B1.

7. Lisa Girion, *Health Insurer Tied Bonuses to Dropping Sick Policyholders*, L.A. TIMES, Nov. 9, 2007, at A1.

8. *See generally Terminations of Individual Health Policies by Insurance Companies: Hearing Before Subcomm. on Oversight and Investigations*, 111th Cong. (2009), *available at* http://energycommerce.house.gov/index.php?option=com_content&view=article&id=1671:energy-and-commerce-subcommittee-hearing-on-terminations-of-individual-health-policies-by-insurance-companies-&catid=133:subcommittee-on-oversight-and-investigations&Itemid=73 (last visited Dec. 29, 2010) [hereinafter *Hearings on Terminations 2009*].

Recently the U.S. House of Representatives held its second hearing on the practice of health insurance rescission, at which Representative Bart Stupak stated: "The companies who engage in these rescissions argue that they are entirely legal, and to a large extent they are. But that goes against the whole point of insurance."[9] This comment will explore the legal merits behind Representative Stupak's comment. Although health insurance can be obtained through public programs, such as Medicare or Medicaid, this comment focuses on private plans, which are those either bought in the individual market or obtained through an employer.

Part I of this comment defines and explores important concepts and terms, such as post-claims underwriting, a practice commonly relied upon by insurers to carryout rescissions. Part II provides a broad overview of laws that regulate employer-sponsored health plans, laws that regulate individual health plans, and their relationship with rescissions. Part III analyzes several notable cases on rescission and various defenses against an insurer's use of rescissions.

I. IMPORTANT CONCEPTS AND TERMS

A. Medical Underwriting and Post-Claims Underwriting

Prior to extending an insurance policy to applicants, insurers typically take on the task of underwriting. Underwriting is the process by which insurers assess an applicant's risk of incurring costs and whether and at what price to offer the applicant a policy.[10] Underwriting protects an insurer's risk pool by identifying high-risk individuals who are likely to incur greater medical expenses.[11] Insurers attempt to minimize the number of high-risk participants because too many of them increases costs for all members of the pool.[12] Adverse selection increases costs because it concentrates risk and leaves fewer healthy, less expensive policyholders to help cover overall expenses.[13]

Underwriting is traditionally conducted pre-issuance and pre-claim.[14] This is the traditional sequence because it determines the likelihood of future losses, whether the insurer wants to accept those losses, and what premium to apply to make-up for those losses.[15] In essence, the insurer must know the risks it is undertaking before it agrees to accept them.[16] Once a policy has been issued, the insured is presumably assured that his or her health care costs will be covered.[17] Accordingly, a number of courts have found that the insured's reliance on the availability of

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9. Allison Torres Burtka, *Lawsuits, Congress, Chip Away at Health Insurance Rescissions*, TRIAL MAG., Aug. 2009, at 16.

10. ROBERT H. JERRY, UNDERSTANDING INSURANCE LAW §§ 11, 18 (2d ed. 1996).

11. HILARY HAYCOCK, MEREDITH KING LEDFORD & PETER HARBAGE, ROBERT WOOD JOHNSON FOUND., PRIMER ON POST CLAIMS UNDERWRITING AND RESCISSION PRACTICES: FINDINGS FROM TEXAS IN THE INDIVIDUAL HEALTH INSURANCE MARKET 2 (2009), http://www.rwjf.org/files/research/texascasestudyaug2009.pdf.

12. *Id.*

13. *Id.*

14. Thomas C. Cady & Georgia L. Gates, *Post Claims Underwriting*, 102 W. VA. L. REV. 809, 812 (2000).

15. *Id.*

16. *Id.*

17. *Id.*

coverage creates a duty, independent of any statute, on the insurer to conduct its underwriting before the policy is issued.[18]

Post-claims underwriting, unlike traditional underwriting, occurs when information is gathered regarding a participant's application and health status subsequent to a claim.[19] Thus, the insurer does not assess the insured's risks and eligibility until after a policy is issued and a claim is filed.[20] Post-claims underwriting can be difficult to distinguish from post-claims investigation.[21] In fact, in some states a post-claims investigation is permitted, even if post-claims underwriting is prohibited.[22] The difficulty in discerning post-claims underwriting from post-claims investigation is due to the similarity in the activities, in that both require research into an applicant's health following issuance of the policy.[23] However, when post-claims underwriting occurs, the insurer does not assess an applicant's actual risks prior to issuing the policy.[24] One court has asserted that the ability to identify post-claims underwriting from post-claims investigation lies in the quality of the underwriting process before the policy is issued.[25]

Though post-claims underwriting is permitted in many states, some, like California, have outlawed the practice by statute,[26] recognizing that the practice leads to unexpected cancellations of health care coverage at a time it is needed most.[27] These types of laws may be read as not only prohibiting post-claim underwriting, but also as creating a duty for insurers to conduct a thorough underwriting process prior to issuing a policy.[28] When post-claims underwriting laws are enforced, they limit policyholders' risk of their policies being rescinded.[29] This is because, by conducting a thorough underwriting process prior to issuing a policy, the insurer would presumably discover all or most of the applicant's omitted medical informa-

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18. *See* Hailey v. Cal. Physicians' Serv., 69 Cal. Rptr. 3d 789, 802 (Cal. Ct. App. 2008) (interpreting "medical underwriting to require a plan to make reasonable efforts to ensure a potential subscriber's application is accurate and complete"(internal quotations omitted)); Lewis v. Equity Nat'l Life Ins. Co., 637 So. 2d 183, 188–89 (Miss. 1994) ("[A]n insurer has an obligation to its insured to do its underwriting at the time a policy application is made, not after a claim is filed.").

19. Cady & Gates, *supra* note 14, at 813; *see also* Meyer v. Blue Cross & Blue Shield, 500 N.W. 2d 150, 153 (Minn. Ct. App. 1993) (stating that post-claims underwriting (referred to as "retroactive underwriting") occurs when the insurer will examine an application and request additional information only after a claim has been filed).

20. Cady & Gates, *supra* note 14, at 813.

21. Nw. Mut. Life Ins. Co. v. Babayan, 430 F.3d 121, 138 (3d Cir. 2005) ("[P]ost-claim underwriting itself is nebulous, particularly because it is difficult to draw a distinction between post-claim eligibility investigation and post-claim underwriting." (internal quotations omitted)).

22. *Hailey*, 69 Cal. Rptr. 3d at 800 (accepting the argument that the California statute prohibits post-claims underwriting but does not prohibit post-claims investigation); *see also* O'Donnell v. Allstate Ins. Co., 734 A.2d 901, 907 (Pa. Super. Ct. 1999) (finding that post-claims investigation is not an indication of bad faith).

23. *Hailey*, 69 Cal. Rptr. 3d at 800.

24. Cady & Gates, *supra* note 14, at 813.

25. *Hailey*, 69 Cal. Rptr. 3d at 800.

26. CAL. HEALTH & SAFETY CODE § 1389.3 (West 1993). In addition to California, other states that prohibit post-claims underwriting include Connecticut, CONN. GEN. STAT. ANN. § 38a-477b (West 2000), Minnesota, MINN. STAT. § 62S.21 (2005), and Montana, MONT. CODE ANN. § 33-18-215 (2009).

27. *Hailey*, 69 Cal. Rptr. 3d at 800 (referring to the purpose of California's law against post-claims underwriting).

28. *See id.* at 802 (finding that California's restriction on post-claims underwriting, read in conjunction with its legislative intent, to prevent unexpected cancellation of health care coverage at a time that it is needed most, necessitates insurers duty to make reasonable efforts to ensure a beneficiary's applications is accurate and complete).

29. HAYCOCK ET AL., *supra* note 11, at 7.

tion and thus be precluded from rescinding a policy, because no new information could be discovered. On the other hand, laws that prohibit post-claims underwriting may also make insurance harder to obtain because of both increased cost and more discoveries that lead to increased denials due to preexisting health conditions.[30]

In the absence of prohibitory laws, a number of courts have condemned post-claims underwriting. Some courts have found the practice fraudulent and illegal or evidence of bad faith.[31] One court suggests that post-claims underwriting violates the right of insureds to collect benefits when due.[32] This would indicate that the insurer is calculating whether the claims exceed premiums and raises an inference of bad faith.[33] Another court has stated that insurers use post-claims underwriting to avoid paying benefits by looking for, "all the things in the application that you might be able to dig up that would allow you to rescind the policy."[34] This may expose the insurer to liability if the delay or denial is unreasonable or without proper cause.[35] However, if the delay in benefits is the result of an insurer's "genuine dispute" about the existence of a beneficiary's coverage or liability amount, the insurer may avoid liability for bad faith.[36]

A "genuine dispute" may relate to whether the insurer misrepresented information in her application. If this is the case, in some jurisdictions, the policy can be properly rescinded.[37] Yet, in other jurisdictions a "genuine dispute" may not relieve the insurer of liability if the law recognizes, either through statute or common law, an obligation to do underwriting at the time an application is made.[38] In such circumstances, the insurer may be precluded from rescinding a policy because, had the insurer conducted a thorough pre-issuance underwriting process, it would have discovered the known risks it was accepting and determined whether to deny the application.[39]

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30. *Id.*

31. *See, e.g.*, Provident Indem. Life Ins. Co. v. James, 506 S.E.2d 892, 894–95 (Ga. Ct. App. 1998) (concluding that post-claim underwriting was a basis for a fraud claim); Meyer v. Blue Cross & Blue Shield, 500 N.W.2d 150, 154 (Minn. Ct. App. 1993) (permitting a jury to decide whether post-claim underwriting was a tactic used to avoid paying claims); Ingalls v. Paul Revere Life Ins., 561 N.W.2d 273, 284–85 (N.D. 1997) (holding that post-claims underwriting was evidence of fraud or malice and could sustain a claim for bad faith).

32. *See* Cady & Gates, *supra* note 14, at 818–19 (discussing Lewis v. Equity Nat'l Life Ins. Co., 637 So. 2d 183 (Miss. 1994)).

33. *See Hailey*, 69 Cal. Rptr. 3d at 805 (finding evidence of bad faith when Blue Cross Blue Shield decided not to revoke the Hailey's policy despite evidence of misrepresentation). In *Hailey*, Blue Cross Blue Shield rescinded the insured's policy after the Haileys subsequently filed a more expensive claim. *Id.* This "wait and see" attitude, which allowed Blue Cross Blue Shield to continue to collect premiums until a more serious accident occurred, raised the inference of bad faith. *Id.*

34. *Ingalls*, 561 N.W.2d at 285 (internal quotations omitted).

35. *Hailey*, 69 Cal. Rptr. 3d at 805.

36. *Id.*

37. John Dwight Ingram, *Misrepresentations in Applications for Insurance*, 14 U. MIAMI BUS. L. REV. 103, 103 (2005).

38. *Hailey*, 69 Cal. Rptr. 3d at 805 ("'The genuine dispute rule does not relieve an insurer from its obligation to thoroughly and fairly investigate, process and evaluate the insured's claim. A *genuine* dispute exists only where the insurer's position is maintained in good faith and on reasonable grounds.'" (emphasis in original) (quoting Wilson v. 21st Century Ins. Co. 171 P.3d 1082, 1089 (2007))).

39. *See* Cady & Gates, *supra* note 14, at 816 ("If an insurer chose to insure a risk without expending the necessary resources and time to underwrite before issuance of a policy, it should be held to the consequence of its unenlightened gamble.").

In order to truly assess and accept risks, insurers should conduct underwriting before a policy is issued. Post-claims underwriting undercuts the objective to truly assess and accept risks and can reflect evidence of bad faith. Though it may be difficult to distinguish post-claims underwriting from post-claims investigation,[40] courts have demonstrated that they are able to differentiate between the two.[41] The distinction between post-claims underwriting and post-claims investigation is that post-claims underwriting does not assess an applicant's actual risks before issuing the policy, whereas a proper underwriting would.[42]

B. Rescissions and Cancellations

A rescission retroactively cancels health benefits, including current benefits and previously submitted claims, and returns the entire amount of premiums paid by the insured.[43] A rescission is different from a cancellation: a cancelled policy discontinues current and future benefits, but previously filed claims are still paid.[44] Actions taken other than rescission or cancellation after the discovery of a material misrepresentation may include a retroactive coverage rider or a retroactive premium increase based on the newly identified risk.[45] A retroactive coverage rider is an amendment to a policy that expands or restricts its benefits or excludes certain conditions from coverage.[46]

C. Statutory Standards for Rescission

Rescission is a drastic remedy and courts should be reluctant to grant it.[47] Nevertheless, in most circumstances, an insurer is legally permitted to rescind a policy if any material misrepresentation is discovered in an insured's enrollment application.[48] A misrepresentation occurs when certain facts in an application are misreported either because of an incomplete or incorrect answer to a question.[49] A misrepresentation is material if the newly disclosed information affects the risk undertaken by the insurer—e.g., the newly discovered information would have changed the premium charged.[50] Under the "any material misrepresentation" stan-

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40. *See* Nw. Mut. Life Ins. v. Babayan, 430 F.3d 121, 138 (3d Cir. 2005) ("[P]ost-claim underwriting itself is nebulous, particularly because it is difficult to draw a distinction between post-claim eligibility investigation and post-claim underwriting." (internal quotations omitted)).

41. *See, e.g.*, *Hailey*, 69 Cal. Rptr. 3d at 800 (stating that the ability to identify post-claims underwriting from post-claims investigation lies in the quality of the underwriting process before the policy is issued).

42. Cady & Gates, *supra* note 14, at 813.

43. LEE R. RUSS & THOMAS S. SEGALL, COUCH ON INSURANCE § 30:3 (3d ed. 2006).

44. HAYCOCK ET AL., *supra* note 11, at 4.

45. In order to retroactively increase the premium, the policy may have to contain a provision that allows for such an action as an alternative to rescission. *See* Werdehausen v. Benicorp Ins. Co., 487 F.3d 660, 665–67 (8th Cir. 2007) (distinguishing the Werdehausen's policy from another that lacked a provision contained in the Werdehausen's policy contract that gave Benicorp, the insurance company, the option of retroactively increasing the premium instead of an automatic rescission, and as a result, because Benicorp automatically rescinded the policy, the court reversed the lower court's summary judgment motion for Benicorp).

46. RUSS & SEGALL, *supra* note 43, § 18:17.

47. *Id.* § 31:70 (citing Union Ins. Exch. Inc. v. Gaul, 393 F.2d 151 (7th Cir. 1968)).

48. Ingram, *supra* note 37, at 103; *see also Werdehausen*, 487 F.3d at 665 (joining other circuit courts by determining that federal common law under ERISA permits an insurer to rescind a health insurance policy obtained through a material misrepresentation or omission).

49. Ingram, *supra* note 37, at 103.

50. *Id.* at 106.

dard the insured's intent in obtaining the policy is irrelevant.[51] A rescission is permitted regardless of whether the misrepresentation is committed innocently or knowingly.[52]

However, other states have adopted a higher standard than the "any material misrepresentation." For example, some states use the "intent to deceive" standard, where the insurer must present evidence that the insured's statement was knowingly false.[53] While this standard may protect policyholders whose misrepresentation is committed innocently or negligently, some contend that the cost of this protection will be unfairly borne by diligent policyholders who did not commit a misrepresentation.[54] What is more, there may be reluctance on the part of jurors or judges to find for the insurer, even with strong evidence of the insured's act of fraud.[55] There may be a natural tendency to sympathize with the insured given the huge financial burden that results from such a ruling.[56] However, such concerns may be unwarranted, as many cases have found against the insured notwithstanding the substantial financial burden imposed on the claimant.[57]

Employer-sponsored health insurance policies are generally governed by federal law—the Employee Retirement Income Security Act (ERISA).[58] Unlike most state laws that regulate individual plans, there is no provision in the federal law that allows rescissions as a remedy for misrepresentation.[59] Because ERISA does not have a provision that allows rescission, courts rely on federal common law to review improper rescission claims of ERISA-governed plans.[60] In formulating the federal common law standard, courts seek direction from state laws to the extent that states' laws do not conflict with other ERISA provisions or policies.[61] Under such an approach, a number of federal circuit courts have concluded that rescissions are proper if insurance policies are procured as a result of a material misrepresentation or omission.[62] These courts do so notwithstanding that both the Health

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51. *Id.* at 104.

52. *Id.*

53. *Id.* at 105; *see also Rescission of Individual Health Insurance Policies: Hearing Before the H. Comm. on Oversight and Government Reform*, 110th Cong. (2008), *available at* http://www.hhs.gov/asl/testify/2008/07/t20080717a.html (last visited Dec. 29, 2010) [hereinafter *Hearings on Rescission of Policies 2008*] (statement of Abby L. Block, Director, Center for Drug and Health Plan Choice in the Centers for Medicare & Medicaid Services) (explaining that states have a variety of standards that permit rescissions only if there is evidence of fraud or willful misrepresentation).

54. Ingram, *supra* note 37, at 106.

55. *Id.*

56. *Id.*

57. *See, e.g.*, Spencer v. Ark. Blue Cross & Blue Shield, 205 Fed. Appx. 652, 654 (10th Cir. 2006); *In re* Shipley v. Ark. Blue Cross & Blue Shield, 333 F.3d 898, 902 (8th Cir. 2003); Scarangella v. Group Health, Inc., No.05 Civ. 5298, 2009 U.S. Dist. LEXIS 23457, at *54 (S.D.N.Y. Mar. 24, 2009).

58. *See infra* text accompanying notes 81–84.

59. *In re Shipley*, 333 F.3d at 901.

60. *See, e.g.*, *id.*; McDaniel v. Med. Life Ins. Co., 195 F.3d 999, 1002 (8th Cir. 1999) (explaining that federal common law governs if ERISA lacks a controlling provision).

61. *See, e.g.*, *McDaniel*, 195 F.2d at 1002; Mohamed v. Kerr, 53 F.3d 911, 913 (8th Cir. 1995).

62. *In re Shipley*, 333 F.3d at 901; *see also* Sec. Life. Ins. Co. of Am. v. Meyling, 146 F.3d 1184, 1191 (9th Cir. 1998) (concluding that rescission as a remedy is proper when misrepresentations are made regarding an applicant's health); Davis v. Centennial Life Ins. Co., 128 F.3d 934, 943–44 (6th Cir. 1997) (applying well-known principles of contract law to examine how a misrepresentation affects an ERISA insurance application); Hauser v. Life Gen. Sec. Ins. Co., 56 F.3d 1330, 1333–35 (11th Cir. 1995) (assuming that a right of rescission exists under federal common law used by ERISA).

Insurance Portability and Accountability Act (HIPAA)[63] and a growing number of states require proof of intentional fraud or bad faith.[64] The reasons behind adopting the majority "any material misrepresentation" approach is that it furthers ERISA's objective of regulatory uniformity, it facilitates available and affordable health insurance, and it is consistent with general principles of contract and insurance law.[65] Additionally, courts, such as the Eighth Circuit, are reluctant to part from the majority approach without an indication from Congress to do otherwise.[66]

The newly enacted Patient Protection and Affordable Care Act (PPACA) is such an indication. The statute prohibits "a group health plan and health insurance issuer offering group or individual health insurance" from rescinding a plan enrollee except in cases of fraud or intentional misrepresentation.[67] Because Congress specifically included group plans in its prohibition against rescissions, it suggests that this provision should apply to both individual and ERISA plans.[68] As a result, the federal common law standard for rescission, "any material misrepresentation," should be supplanted by the higher intentional misrepresentation standard. However, whether this provision and the purpose behind it—to prevent cancellation of health care when one gets sick[69]—will operate as intended is unclear. One indication that it may not is that many states already had such laws, e.g., California and Texas, and yet questionable rescissions still persisted in those states.[70] However, recent successes in California and New Mexico in limiting the number of rescissions suggest that tougher laws and greater enforcement can help protect consumers from undue rescission.[71]

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63. *See infra* notes 177–78.

64. *E.g.*, California, CAL. HEALTH & SAFETY CODE § 1365(a)(2) (2008); Connecticut, CONN. GEN. STAT. § 38a-477b(a) (2000); Florida, FLA. STAT. § 627.6425(2)(b) (2005); New Mexico, NMSA 1978, § 59A-22-5(A) (2010); Texas, 28 TEX. ADMIN. CODE § 3.3038(c) (Westlaw through Dec. 2010).

65. *See In re Shipley*, 333 F.3d at 902–903; McBride v. Hartford Life & Accident Ins. Co., No. 05-6172, 2007 U.S. Dist. LEXIS 16917, at *62 (E.D. Pa. Jan. 29, 2007) (stating that the federal view aligns with principles of traditional contract law so that an agreement can be rescinded when it is entered on the basis of a fraudulent or material misrepresentation). *But cf.* Johnson v. Conn. Gen. Life Ins. Co., 324 Fed. Appx. 459, 467 (6th Cir. 2009) (refraining from deciding whether federal common law requires insurers to prove an insured knowingly provided a false answer in order to rescind coverage for a material misrepresentation).

66. *See In re Shipley*, 333 F.3d at 903.

67. Patient Protection and Affordable Care Act, Pub. L. No. 111–148, § 2711(a), 124 Stat. 119, 131 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111–152, 124 Stat. 1029 (2010) [hereinafter collectively known as the Patient Protection and Affordable Care Act].

68. Telephone Interview with Deborah Armstrong, Executive Director of the New Mexico Medical Insurance Pool (Apr. 27, 2010) (stating that Section 2712 will apply to ERISA plans if it is determined by the proper administrative entity that it will apply to group plans). Section 2712 is part of a group of sections entitled "Individual and Group Market Reforms." This title, in addition to the language in the provision, which expressly includes group health plans, provides very strong evidence that Congress intended this provision to apply to ERISA plans, although as of April 2010 it does not appear that such a determination has been made.

69. *See* Democratic Policy Committee, Patient Protection and Affordable Care Act: Insurance Market Reforms that Protect Consumers, http://dpc.senate.gov/healthreformbill/healthbill67.pdf (last visited May 31, 2010) (stating that the health reform bill prohibits insurers from "rescinding health coverage when a beneficiary gets sick as way of avoiding paying that person's health care bills").

70. Between 2008 and 2009, insurers agreed to eight rescission-related settlements that included the reinstatement of thousands of improperly rescinded policyholders. *See infra* note 195; Cal. Dep't of Ins. News Release, *Insurance Commissioner Steve Poizner Announces $15 Million Settlement with Blue Cross Over Rescission Practices*, (Feb. 11, 2009), http://www.insurance.ca.gov/0400-news/0100-press-releases/0080-2009/release017-09.cfm.

71. *See infra* notes 197, 199, and accompanying text.

D. Insurance Law and Rescissions

Many of the laws and principles that govern insurance are based on contract law.[72] In contract law, if an agreement is made without full disclosure of relevant terms, the innocent party is allowed to void, or rescind, the contract.[73] The goal of a rescission—an equitable remedy—is to restore parties to their pre-contractual positions or to bring about "substantial justice by adjusting the equities between the parties despite the fact that the status quo cannot be exactly reproduced."[74] Drawing on principles of ancient ecclesiastical English courts, from which the remedy of rescission grew, today's courts follow the maxim that "[n]o one may profit from his wrong."[75] In applying these remedial concepts in the insurance context, an insurer who wishes to rescind a policy is restricted by this rule of restoration: to rescind a contract it also must return the other party to the status quo ante.[76] Although, in the health insurance context, rescission may never truly restore the insured back to his or her status quo ante, which is an issue that will be discussed further in Part III.E.

II. LEGAL DIFFERENCES BETWEEN EMPLOYER-SPONSORED PLANS AND INDIVIDUAL PLANS

A. Employer-Sponsored Plans

Over two hundred million U.S. citizens get health care coverage from the private market, either through an employer or from the purchase of an individual plan.[77] Though employer-sponsored insurance continues to be the primary source of American's health insurance, the recent economic downturn and increasingly expensive cost of coverage may lead to fewer employers offering insurance to their employees.[78] This could be exacerbated by the anticipated increased costs of health

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72. *See* 43 AM. JUR. 2D *Insurance* § 183 (2009).

73. *See* RESTATEMENT (SECOND) OF CONTRACTS § 164 (1981).

74. Hailey v. Cal. Physicians' Serv., 69 Cal. Rptr. 3d 789, 801 (Cal. Ct. App. 2008) (citing Neptune Society Corp. v. Longanecker, 240 Cal. Rptr 117, 124 (1987)).

75. Barry Zalma, *Rescissions*, 37 UWLA L. REV. 204, 204–205 (2004).

76. *See, e.g.*, Riley v. Hoisington, 96 S.W.3d 743, 749 (Ark. Ct. App. 2003) (stating that, in an action for rescission the court applies equitable principles to attempt to restore the status quo); EarthInfo Inc. v. Hydrosphere Res. Consultants, Inc., 900 P.2d 113, 118 (Colo. 1995) (contending that the rescission of a contract usually means restitution on both sides); Groothand v. Schlueter, 949 S.W.2d 923, 930 (Mo. Ct. App. 1997) (stating that "the purpose [of rescission] is to return the parties to the status quo . . . the position they occupied prior to entering the contract"); *see also* RESTATEMENT (SECOND) OF CONTRACTS § 384 (1981) (section titled "Requirement That Party Seeking Restitution Return Benefit"). The status quo ante is the "situation that existed before something else . . . occurred." BLACK'S LAW DICTIONARY 1542 (9th ed. 2009).

77. CARMEN DENAVAS-WALT, BERNADETTE D. PROCTOR & JESSICA C. SMITH, US CENSUS BUREAU, INCOME, POVERTY, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2007 19–20 (2008). This comment will focus on these types of health care insurance policies, although it is worth noting that many Americans receive their health coverage from Medicaid, Medicare, State Children's Health Insurance Program (SCHIP), or the Veteran's Health Administration.

78. Elizabeth A. Pendo, *The Health Care Choice Act: The Individual Insurance Market and the Politics of "Choice,"* 29 W. NEW ENG. L. REV. 473, 474–75 (2005). In 2007, 59.3% of Americans were covered by employment-based health insurance, or approximately 177,000 people, down from 59.7% in 2006. DENAVAS-WALT ET. AL., *supra* note 77, at 19. Similarly, the percentage of people covered by individual health plans decreased from 9.1% in 2006 to 8.9% in 2007. On the other hand, government health insurance programs increased to 27.8% in 2007, from 27.0% in 2006. *Id.* at 19–20. However, a recent report indicates that the number of individual health policy applications has dramatically increased, likely due to the recession. Julie Appleby, *Costs for Individual Health Plans Soar*, USA TODAY, Feb. 20, 2009, *available at* http://www.usatoday.

care caused by the newly enacted health reform legislation.[79] The legal and regulatory differences between employer-sponsored plans and individual policies are in some circumstances significant.[80]

Employer-sponsored health plans are generally controlled by ERISA. Although ERISA plans are subject to state law in some instances, to what extent and under what circumstances continues to produce significant litigation.[81] This is because ERISA expressly preempts any state law that "relate[s] to any employee benefit plan,"[82] but does not "exempt or relieve any person from any law of any State which regulates insurance."[83] The latter provision, known as the savings clause, retains a state's traditional ability to regulate insurance.[84] Ultimately, it is difficult to distinguish insurance regulation, for which states retain the power to control, from regulation of benefits, which is expressly preempted by ERISA.

In addition to generally prohibiting state laws that regulate plan benefits, ERISA also expressly preempts any claims pertaining to the "recover[y] [of] benefits due . . . under the terms of [the] plan, to enforce . . . rights under the terms of [the] plan, or to clarify . . . rights to future benefits under [the] terms of the plan."[85] The Supreme Court has interpreted this ERISA provision to preclude any state causes of action that "duplicate, supplement, or supplant" ERISA remedies.[86] As a result, state laws that regulate an insurer's ability to rescind policies may fall within this preemptive power of ERISA[87] because ERISA already has a common law rule for the standard by which an insurer can rescind a policy.[88] While ERISA regulated plans are exempt from many state regulations,[89] such plans charge insurers with a fiduciary duty to the insureds.[90] Courts have interpreted ERISA's fiduci-

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com/news/health/2009-02-19-health-coverage_N.htm (last visited Nov. 28, 2010) ("A website that links people with insurers, eHealthInsurance, says applications are up 18% in the fourth quarter, compared with a year ago.").

79. *See* Shawn Tully, *Documents Reveal AT&T, Verizon, Others, Thought About Dropping Employer-Sponsored Benefits*, CNN, May 6, 2010, http://money.cnn.com/2010/05/05/news/companies/dropping_benefits.fortune/ (last visited Nov. 28, 2010).

80. For example, employer-sponsored plans are controlled by ERISA, and ERISA creates a fiduciary relationship between the insurer and insured. *Infra* text accompanying note 90. This fiduciary relationship imposes a duty of loyalty on the insurer. *Id.* However, depending on the jurisdiction insurers of individual health plans may not have a fiduciary duty to their insured. *See infra* text accompanying notes 120–26.

81. 29 U.S.C. § 1144(a) (2006); *see, e.g.*, Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355 (2002) (holding that a state law that provides for an external review of medical claims before litigation was an insurance regulation and not preempted by ERISA). *But cf.* Shaw v. Delta Air Lines, 463 U.S. 85 (1983) (holding that a state human rights law was preempted by ERISA because it prohibited practices that were lawful under ERISA).

82. 29 U.S.C. § 1144(a) (2006).

83. *Id.* § 1144(b)(2)(a).

84. *Id.*

85. *Id.* § 1132(a)(1)(B).

86. Aetna Health Inc. v. Davila, 542 U.S. 200, 209 (2004).

87. *See* Tingle v. Pac. Mut. Ins. Co., 996 F.2d 105, 107–10 (5th Cir. 1993) (finding that a state law relating to insurance misrepresentations is preempted by ERISA).

88. *See supra* text accompanying notes 59–66.

89. Despite ERISA's broad preemptive power, some state laws are enforceable under ERISA's "saving clause" or because the state law is too tenuously related to the plan to fall within ERISA express preemption. *Shaw*, 463 U.S. at 100 n.21; *see also* Rush Prudential HMO v. Moran, 536 U.S. 355 (2002) (holding that states could enact and enforce laws applicable to ERISA insurers that require external review of challenged benefits decisions).

90. 29 U.S.C. § 1104 (2006).

ary duties broadly,[91] applying them to any entity that has any control or authority over a plan, including plan sponsors or third-party insurers.[92]

An ERISA fiduciary relationship imposes two main duties on the insurers: the duty to exercise prudence and the duty of loyalty.[93] Specifically, the duty of loyalty requires an insurer to act "solely in the interest of the participants and beneficiaries" of the plan.[94] However, these terms were not defined by ERISA or the courts, and therefore an examination of a fiduciary breach tends to be fact specific.[95]

The duty of loyalty is particularly relevant with regard to rescissions. The duty of loyalty demands that a fiduciary make decisions without a conflict of interest that might influence the ability to act in a beneficiary's best interests.[96] An insurer must walk a tightrope in this respect, as its shareholders and beneficiaries may have conflicting interests giving rise to conflicting duties.[97] For example, an insurer's duty to shareholders creates an inherent financial motive to minimize claims paid, and consequently an insurer's denial or approval of benefits "lies in perpetual conflict with its status as a business."[98] Cognizant of this inherent conflict, courts focus not on whether there was such a conflict, but rather if the decision in the specific case was indeed motivated by a conflict that impeded sound judgment.[99] The purview of this review may also vary depending on whether the policy has a provision that permits discretionary authority to interpret and determine eligibility for benefits.[100] The presence of such a provision affects the scrutiny under which courts review an insurer's decision to rescind, or for that matter any benefit decisions.[101] If there is a contractual provision that grants the insurer discretionary authority, courts review the insurer's decision under a deferential abuse of discretion standard.[102] If the contract does not provide the insurer such authority, courts will review contract claims de novo, a substantially more rigorous standard of review.[103]

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91. *See* Donovan v. Mercer, 747 F.2d 304, 308 (5th Cir. 1984) ("Congress intended the definition of 'fiduciary' under ERISA to be broadly construed . . . [and] should be defined not only by reference to particular titles . . . but also by considering the authority which a particular person has. . . .").

92. Clifford Cantor, *Fiduciary Liability in Emerging Health Care*, 9 DEPAUL BUS. L.J. 189, 195–97 (1997).

93. Peter Jacobson & Michael Cahill, *Applying Fiduciary Responsibilities in the Managed Care Context*, 26 AM. J.L. & MED. 155, 160 (2000).

94. 29 U.S.C. § 1104 (a)(1).

95. Jacobson & Cahill, *supra* note 93, at 160.

96. *Id.*

97. *Id.* For example, an individual beneficiary may have an interest in obtaining a specific, expensive treatment, whereas other plan participants have an interest in maintaining plan assets for their health care expenses. *Id*.

98. Cantor, *supra* note 92, at 198–99 (citing Doe v. Group Hospitalization & Medical Servs., 3 F.3d 80, 86 (4th Cir. 1993)).

99. Jacobson & Cahill, *supra* note 93, at 161.

100. *See, e.g.*, Werdehausen v. Benicorp Ins. Co., 487 F.3d 660, 664 (8th Cir. 2007) (stating that the Werdehausen's policy contract granted Benicorp, the insurer, discretionary authority to interpret the policy and determine benefit eligibility).

101. *Id.*; *Doe*, 3 F.3d at 85.

102. *See* Firestone Tire & Rubber Co. v. Brunch, 489 U.S. 101, 115 (1989) (requiring that courts limit their review to abuse of discretion if the plan expressly provides insurers with discretionary authority).

103. *Doe*, 3 F.3d at 85; *Werdehausen*, 487 F.3d at 664 (stating that de novo review is a less deferential standard of review).

Once it is determined that a claim will be reviewed under an abuse of discretion standard, a court will look to whether the insurer's decision to rescind was reasonable.[104] A court will usually uphold an insurer's decision unless it was arbitrary or capricious.[105] An exception to this deferential level of review is applied when the insurer's decision was made while acting under an actual financial conflict of interest.[106]

The presence of a financial conflict depends on the circumstances of the case. For example, a conflict may occur when a plan is financed through premiums and profits that are contingent on whether claims exceed expected risks.[107] Alternatively, a financial conflict may exist when an insurer could have retroactively increased premiums to recoup a loss but chose not to do so.[108] If such a financial conflict is present, and if the conflict was directly connected to the benefit decision such that it displayed an arbitrary exercise of fiduciary discretion, a court may apply a higher standard of review, such as de novo.[109]

B. Laws Relating to Individual Plans

Individual plans purchased by the self-employed or unemployed, if not preempted by federal laws like HIPAA, are generally controlled by state law.[110] State insurance laws and regulations are implemented and enforced, though not exclusively, by state departments of insurance.[111] Although there are a myriad of state insurance laws and regulations, only several are relevant to rescission. The remainder of this section will discuss these provisions.

1. Contestability Laws

Contestability laws bar insurers from revoking coverage for any reason other than fraudulent misrepresentation after a policy has been in effect for some period of time, ordinarily two years.[112] Many states have such provisions,[113] and occasion-

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104. *Doe*, 3 F.3d at 85.

105. Jacobson & Cahill, *supra* note 93, at 162.

106. *Doe*, 3 F.3d at 87 (stating that where one interpretation of a disputed contract term will further the financial interests of the fiduciary the court will not act as deferentially as it would otherwise); *see also* Brown v. Blue Cross & Blue Shield of Ala., Inc., 898 F.2d 1556, 1561 (explaining that when a significant conflict of interest is evident the fiduciary has the burden of proving that its interpretation of the plan and benefits was not in self-interest).

107. *See, e.g.*, *Doe*, 3 F.3d at 86 (concluding that a plan financed through contingent premiums and profits presented a substantial conflict of interest causing the court to alter its standard of review).

108. *See Werdehausen*, 487 F.3d at 666 (finding that the insurer's decision to automatically rescind coverage rather than determine if it could retroactively increase premiums demonstrated a palpable conflict of interest that required de novo review).

109. *See, e.g.*, Armstrong v. Aetna Life Ins. Co., 128 F.3d 1263, 1265 (8th Cir. 1997) (deciding to review the insurer's decision to deny benefits de novo because the insurer appeared to be acting under a conflict of interest). Other circuits have adopted different standards to review an insurer's decision, although each entails some heightened level of review. *Id.* For example, the Ninth and Eleventh Circuits adopted a "presumptively void" test, and the Fourth, Fifth, Seventh, and Tenth Circuits use a "sliding scale" approach. *Id.*

110. *See* Anne Maltz, *Health Insurance Fundamentals*, 774 PRACT. L. INST., 213, 232 (2008) (stating that "individual health insurance purchased through the private insurance industry is regulated by federal and state law . . . [state laws] are set by each State's department of insurance").

111. *Id.* at 224.

112. *See* PETER HARBAGE, HILARY HAYCOCK & MEREDITH KIND LEDFORD, POST CLAIMS UNDERWRITING AND RESCISSION PRACTICES 6 (2009), http://www.rwjf.org/files/research/52428.pdf; *see also* CAL. INS. CODE § 10350.2 (2005) ("After two years from the date of issue of this policy, no misstatements, except fraud-

ally contestability provisions are present in the actual policy.[114] The presence of contestability periods in state law or contract clauses leads some to believe that the first two years of coverage pose the greatest risk of rescission.[115] This is because many states have a lower intent standard than that required for fraud, and thus during the first two years of coverage an insurer can rescind a policy without evidence of fraud.[116] Contestability laws may also conflict with HIPAA's guaranteed renewability provision, an issue that will be discussed in further detail in Part III.B .[117] On the other hand, contestability laws may offer consumers a considerable amount of protection from rescission once the requisite time period is met.[118] For once a policyholder meets the requisite time period, an insurer is barred from rescinding policies except in cases of strong evidence of fraud.[119]

2. Fiduciary Duties Under State Law

Insurers of individual health plans may also be subject to the duties of a fiduciary. However, unlike the broad uniformly imposed fiduciary duties of ERISA insurers, the existence of a fiduciary duty in the individual market depends on the laws and jurisprudence of a particular jurisdiction. A fiduciary relationship between an insurer and insured in the individual market may be statutorily imposed,[120] derived from common law,[121] or nonexistent.[122] However, even jurisdictions that establish a fiduciary duty between an insurer and insured may do so under limited circumstances.[123]

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ulent misstatements, made by the applicant in the application for the policy shall be used to void the policy or to deny a claim for loss incurred or disability. . . .").

113. HARBAGE ET AL., *supra* note 112, at 6.

114. RUSS & SEGALL, *supra* note 43, § 31:81.

115. *See infra* text accompanying notes 184–85.

116. *See infra* text accompanying note 185; *see also supra* notes 51–52 and accompanying text.

117. *See infra* text accompanying notes 178–84.

118. *See, e.g.*, Velez Gomez v. SMA Life Assur. Co., 793 F. Supp. 378 (D.P.R. 1992) (prohibiting the insurer from contesting the policy of an insured who had multiple sclerosis and failed to disclose that he had the condition at the time he applied because more than two years had elapsed from the time the policy was issued); Cal. Welfare Galanty v. Paul Revere Life Ins. Co., 1 P.3d 658, (Cal. 2000) (barring the insurer from denying coverage after the policy had been in force for two years despite the fact that the insured's sickness manifested before the policy's date of issue).

119. *See, e.g.*, Protective Life Ins. Co. v. Sullivan, 682 N.E.2d 624 (Mass. 1997) (denying the insurer the ability to rescind even though the life insurance applicant willfully concealed a medical condition because the two-year contestability period had expired).

120. *See, e.g.*, Mahler v. Szucs, 957 P.2d 632, 641 (Wash. 1998) (stating that a Washington statute "creates a fiduciary duty for insurers running to their insureds").

121. *See, e.g.*, Polselli v. Nationwide Mut. Fire Ins. Co., 126 F.3d 524, 530–31 (3d Cir. 1997) (explaining that the insurer's duty of good faith toward an insured is implicit in every insurance policy); Pareti v. Sentry Indem. Co., 536 So.2d 417, 423 (La. 1988) (deciding that an insured did not fulfill its fiduciary duty by failing to discharge its policy obligations); Fireman's Fund Ins. Co. v. Sec. Ins. Co., 367 A.2d 864, 866 (N.J. 1976) (concluding that the insurer disregarded its fiduciary duty by refusing to contribute its policy limits towards the proposed settlement). *But see* Douglas R. Richmond, *Trust Me: Insurers Are Not Fiduciaries to Their Insureds*, 88 KY. L.J. 1 (2000) (arguing that insurance policies are contracts and under the principles of contract law should be free of restrictive fiduciary duties).

122. *See, e.g.*, Batas v. Prudential Ins. Co. of America, 724 N.Y.S.2d 3 (N.Y. App. Div. 2001) (concluding that New York law does not impose a general fiduciary relationship between a health insurer and its beneficiaries); National Plan Adm'rs, Inc. v. National Health Ins. Co., 235 S.W.3d 695 (Tex. 2007) (holding that the insurance code did not instill a general fiduciary duty on health insurers).

123. *See generally* Richmond, *supra* note 121.

Absent a fiduciary relationship, a policyholder may have fewer legal avenues to remedy a rescission or seek redress for breach of fiduciary duty, which would be permitted under ERISA. For instance, unlike a fiduciary insurer a non-fiduciary insurer is allowed to give its own interests "equal consideration."[124] Notwithstanding the absence of a fiduciary relationship, insurers and plan participants must still abide by the terms of their contract, which in some jurisdictions imposes a duty of good faith and fair dealing.[125] This duty, in turn, spawns an insured's complaints of insurer bad faith.[126] And unlike ERISA policyholders' claims, bad faith claims brought under state law by individual policyholders are not preempted. Therefore, policyholders of individual plans may instead seek redress under state claims of bad faith.

3. Duty of Good Faith and Fair Dealing

Insurance law draws many of its rules from contract law, including an insurer's implied duty of good faith and fair dealing.[127] This duty is imposed on the insurer because of the parties' unequal bargaining power, which might otherwise allow insurers to take advantage of an insured's misfortune in seeking settlement or resolution of a claim.[128] Thus, the duty of good faith forbids parties from taking "advantage of the vulnerabilities created by the sequential character of contractual promises."[129] Courts have considered the promise of good faith performance implied in insurance contracts as a means to protect insured's from insurer abuse.[130]

III. Defenses Against Rescission

A. Notable Cases About Rescission

1. Litigating Plans Bought in the Individual Market

In the seminal case of *Hailey v. California Physicians' Service*, the California Court of Appeals heightened the standards for insurer rescission of health insurance policies. The court rejected the insurer's method of underwriting, declaring that it is insufficient to simply rely on an applicant's responses to questions on the application as a method of underwriting.[131] In this case, Cindy Hailey applied for

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124. STEPHEN S. ASHLEY, BAD FAITH ACTIONS LIABILITY & DAMAGES § 10:24 (2009).

125. *See infra* Part II.B.3; *see also* 45 C.J.S. *Insurance* § 584 (2010) ("The general rule is that an insurance policy is a personal contract between the insurer and the named insured . . . [and] a duty of good faith and fair dealing generally runs from the insurance company to the insured.").

126. *See infra* Part II.B.3.

127. *See* RESTATEMENT (SECOND) OF CONTRACTS § 205 (1979) ("Every contract imposes upon each party a duty of good faith and fair dealing in its performance and enforcement."); 43 AM. JUR. 2D *Insurance* § 183 (2010) ("Broadly speaking, 'insurance' is a contract. . . . There are implied, as well as expressed conditions of the contract . . . , [and] implicit in such a contract is the insurer's obligation to deal fairly with its insured.").

128. *See* 45 C.J.S. *Insurance* § 584 (2010) ("[A special] relationship arises out of the parties' unequal bargaining power and the nature of insurance contracts which would allow unscrupulous insurers to take advantage of their insureds' misfortunes. . . ."); 43 AM. JUR. 2D *Insurance* § 185 ("[A]n insurance policy is . . . a 'contract of adhesion' because the insurance contract is drafted solely by the insurer. Thus, an insurance policy is liberally construed in favor of the insured and it is the responsibility of the insurer to write a clear policy with adequately defined terms.").

129. RICHARD POSNER, ECONOMIC ANALYSIS OF LAW § 4.1 (5th ed. 1998).

130. *See* ROBERT H. JERRY & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW § 25G, 176 (4th ed. 2007).

131. Hailey v. Cal. Physicians' Serv., 69 Cal. Rptr. 3d 789, 800 (Cal. Ct. App. 2008).

an individual health plan from Blue Shield of California (Blue Shield) for herself and her family.[132] Although Cindy thought she provided all the information the application requested, she claimed to have mistakenly failed to include full medical histories of her husband, Steve, and their son.[133] Using the information Cindy provided, Blue Shield extended the Haileys a policy.[134] Less than two months after the issuance of the policy, Steve was admitted to the hospital for stomach problems, which prompted Blue Shield to refer the Hailey's contract to its Underwriting Investigation Unit, a unit that investigates potential fraud.[135] In its investigation, Blue Shield discovered that Steve had a history of undisclosed health problems and alleged that the Haileys intentionally misrepresented Steve's medical condition.[136] Notwithstanding this determination, Blue Shield maintained the Hailey's policy.[137]

One month later, Steve got in a car accident that required almost two weeks of hospitalization and additional home nursing care and therapy, which left him completely disabled.[138] Blue Shield authorized health care providers to give Steve over $457,000 in treatment expenses.[139] In June, while receiving home care and therapy services, Steve received notice from Blue Shield that it was rescinding his policy.[140] Blue Shield rescinded the policy on the basis that Cindy failed to fully disclose Steve's medical history.[141] Because the Haileys lost their health coverage, Steve could no longer afford nursing care and therapy and had to delay some treatment.[142] As a result, Steve lost use of his bladder and claimed that without physical therapy his ability to walk was impaired, which in turn increased his pain and brought about additional surgery and medication.[143]

The Haileys sued Blue Shield for breach of contract, breach of implied covenant of good faith and fair dealing, and intentional infliction of emotional distress.[144] Blue Shield argued that in California an insurer is permitted to rescind a policy if an applicant willfully misrepresented his or her medical history and the Haileys willfully misrepresented Steve's medical history.[145] The lower court granted Blue Shield summary judgment, finding Blue Shield was justified in rescinding their policy on the basis of Cindy's omission of Steve's medical history.[146] The appellate court reversed, rejecting the trial court's determination that the Haileys engaged in willful misrepresentation.[147]

The court began by examining California's statute that forbids rescission absent evidence of intentional misrepresentation.[148] Specifically, the statute prohibits in-

132. *Id.* at 795–96.
133. *Id.* at 796.
134. *Id.* at 796.
135. *Id.*
136. *Id.*
137. *Id.*
138. *Id.*
139. *Id.*
140. *Id.*
141. *Id.*
142. *Id.*
143. *Id.* at 796–97.
144. *Id.* at 797.
145. *Id.* at 798.
146. *Id.* at 797.
147. *Id.* at 797, 809.
148. *Id.* at 797–98.

surers from practicing post-claims underwriting for the purpose of rescinding a policy as a result of an insurer's failure to conduct a complete underwriting process.[149] The court rejected Blue Shield's argument that because Cindy omitted part of Steve's medical history, she must have done it willfully.[150] Instead, the court, guided by the purpose of the statute—to prevent the unexpected cancellation of health care coverage at a time it is needed most[151]—considered Cindy's contention that her failure to provide accurate information was due to ambiguous and misleading application questions.[152] In the end, the court overturned Blue Shield's motion for summary judgment because Cindy's contention that she inadvertently failed to disclose Steve's medical history was a triable issue of fact.[153]

The message of *Hailey* is clear: the simple presence of a medical record that contradicts information provided in an insurance application is not enough to prove willful misrepresentation—under a fraud standard, an insurer must show more.[154] Moreover, the court made clear that insurers could no longer rescind policies if their underwriting process simply accepted an application and assigned risk values without confirming an applicant's responses or searching the applicant's medical records.[155] By rejecting Blue Shield's motion for summary judgment, the court signaled to insurers in California that neither unsubstantiated assertions of a policyholder's misrepresentation nor cursory underwriting processes are enough to sustain a summary judgment motion. Although, ultimately on remand a court found in favor of the insurer, the impact of the appellate court's decision "sets the rules of the road going forward."[156]

Plaintiffs have successfully argued in other cases that the insurer failed to conduct a proper underwriting process and thus should be precluded from rescission.[157] Moreover, in states that limit rescissions to instances of fraud some courts appear reluctant to infer fraud, or willful misrepresentation, from simply information newly discovered in an applicant's medical history that was omitted in his or her application.[158]

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149. *Id.* at 798.

150. *Id.*

151. *Id.* at 800–801. ("The unmistakable purpose of [this section] . . . is to prevent the unexpected cancellation of health care coverage at a time coverage is needed most.")

152. *Id.* at 798–99.

153. *Id.* at 799.

154. *But cf.* Nieto v. Blue Shield of Cal. Life & Health Ins. Co., 103 Cal. Rptr. 3d 906, 925–26 (Cal. Ct. App. 2010) (distinguishing Hailey in part because Hailey's policy was governed by a different insurance code that further constrained insurers' ability to rescind).

155. *Hailey*, 69 Cal. Rptr. 3d at 800–01. *But cf. Nieto*, 103 Cal. Rptr. 3d at 927 (declaring that the medical underwriting requirements outlined in *Hailey* did not apply to Nieto's plan).

156. Burtka, *supra* note 9, at 16 (drawing on information provided by William Shernoff, an attorney in California who has litigated numerous rescission claims).

157. *See, e.g.*, Thompson v. Occidental Life Ins. Co., 513 P.2d 353 (Cal. 1973) (putting the burden on the insurer to eliminate all possible explanations for the policyholder's omission of information in a life insurance application); Nazaretyan v. Cal. Physician Serv., 107 Cal. Rptr. 3d 137 (Cal. Ct. App. 2010) (holding for the plaintiffs on the basis that the insurer could not establish that it conducted a proper underwriting process because it merely ensured that no required responses in the application were left blank); Haldi v. Found. Life Ins. Co., 324 S.E.2d 189 (Ga. 1985) (concluding that an insurer could not rescind a life insurance policy when it failed to investigate a condition upon which it later based its rescission).

158. *See, e.g.*, *Nazaretyan*, 107 Cal. Rptr. 3d at 147 (rejecting an insurer's argument that an applicant willfully misrepresented his medical condition because he omitted a visit to the fertility doctor in which the doctor informed him that his fertility problems may be the result of a medical condition); Chism v. Protective

2. Using ERISA's Fiduciary Duty to a Plaintiff's Advantage

Unlike policyholders of plans bought in the individual market, policyholders of ERISA plans cannot use state laws to bring claims of undue rescission. Generally ERISA preempts such laws and courts apply ERISA rules instead.[159] However, recall that ERISA does not have a provision that conveys the availability of rescission, and thus courts rely on federal common law.[160]

In *Werdehausen v. Benicorp Insurance Co.*, Benicorp Insurance rescinded Kenny Werdehausen's employer-sponsored policy on the basis that Werdehausen failed to disclose his need for upcoming surgery.[161] In 2002, Werdehausen completed an enrollment application and in it disclosed that he had recently undergone lower back surgery, but failed to disclose that he would eventually need neck surgery on a herniated disc.[162] Werdehausen claimed that the nondisclosure was innocent and assumed Benicorp would have checked his medical records before accepting his application.[163] Benicorp asserted that Werdehausen's undisclosed need for neck surgery was a material misrepresentation that would have increased premium costs by over $2,000 per month.[164] Moreover, under the insurance policy between Werdehausen and Benicorp, Benicorp was given discretionary authority to interpret and determine benefits, and in the event of the discovery of a material misrepresentation, Benicorp could adjust premiums and/or benefits to reflect the newly discovered information.[165]

The court found that Benicorp's decision to rescind Werdehausen's policy was directly connected to a financial conflict of interest and under such circumstances courts review the insurer's decision under higher scrutiny.[166] Here, Benicorp adopted an internal policy under which it would automatically rescind every alleged instance of misrepresentation, despite a provision in Werdehausen's contract that gave Benicorp the option of retroactively increasing premiums.[167] The court declared that when a plan makes a remedy available, the insurer must act in accordance with its duties as an ERISA fiduciary, and Benicorp's decision to rescind Werdehausen's plan should be reviewed de novo.[168] The court remanded the case back to district court to determine whether another provision from the policy contract precluded Benicorp from retroactively increasing the premium—a fact-finding task consigned to district court.[169]

This case suggests that an insurer's systematic practice of rescission without investigating the circumstances of the case or provisions in the policy can constitute the breach of an insurer's fiduciary duty. Even if such an action is not a breach of a

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Life Ins. Co., 195 P.3d 776 (Kan. Ct. App. 2008) (stating that for an insurer to rescind a life insurance policy on the basis of fraud there must be clear and convincing evidence of fraud).

159. *See supra* text accompanying notes 81–89.
160. *See supra* text accompanying note 60.
161. 487 F.3d 660, 663 (8th Cir. 2007).
162. *Id.*
163. *Id.*
164. *Id.*
165. *Id.* at 664.
166. *Id.*; *see also supra* text accompanying notes 106–109.
167. *Werdehausen*, 487 F.3d at 666.
168. *Id.* at 666–67.
169. *Id.* at 667.

fiduciary duty, it may at least merit stricter scrutiny by a court, which holds promise of added protection for consumers against an unfair rescission. Additionally, the newly enacted Patient Protection and Affordable Care Act, which prohibits rescission except in cases of fraud, may also apply to ERISA plans and override courts' use of the "any material misrepresentation" federal common law standard.[170]

B. HIPAA and Other State Fraud Standards

The practice of post-claims underwriting and rescission is not new to legislators. In 1996, Congress passed HIPAA with the objective of facilitating the portability, access, and renewability of group health plans.[171] Though HIPAA had admirable goals, some argue HIPAA's convoluted and ambiguous provisions cause confusion among practitioners.[172] Consequently, HIPAA may fall short of some its objectives.[173] Of particular relevance to the issue of rescissions and cancellations is HIPAA Section 300gg, which states: "Except as provided in this section, a health insurance issuer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual."[174] A subsequent subsection of the statute clarifies by stating that a "health insurance issuer may nonrenew or discontinue health insurance coverage . . . based . . . on . . . [f]raud," among other things.[175] Fraud is "an act or practice that constitutes fraud or made an intentional misrepresentation of material fact."[176] Based on these provisions, arguments have been made that rescissions done in the absence of fraud violate HIPAA's requirement of guaranteed renewability.[177] However, in most circumstances courts have rejected this argument, find-

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170. Whether the Act will apply to ERISA plans is somewhat unclear; however, statutory construction of section 2712 suggests that it might. Section 2712 includes group health plans in its prohibition against rescission. Furthermore, the objective behind Section 2712 was to safeguard *all* health insurance consumers from undue rescission. Thus, there is strong indication that Section 2712 was intended and will apply to ERISA plans as well as individual plans. *See also supra* note 68.

171. *See generally* 43 AM. JUR. 2D *Insurance* § 552 (2009).

172. *See* Angela Stewart, *HIPAA an Individual-Friendly Concept . . . Not an Individual-Friendly Law*, WYO. LAWYER, 28 Feb. 2005, at 18, 19 ("A major problem with HIPAA is that practitioners do not fully understand HIPAA mandates and individuals have no way of understanding their rights and responsibilities under the act.").

173. *See id.* (arguing that HIPAA fails to provide individuals adequate protections against exclusions based on preexisting conditions and that enforcement of current HIPAA protections are weak).

174. 42 U.S.C. § 300gg-42(a) (2006).

175. *Id.* § 300gg-42(b)(1)–(5).

176. *Id.* § 300gg-42(b)(2).

177. *See, e.g.*, Reply Brief of Appellants-Plaintiffs at 17, Spencer v. Ark. Blue Cross & Blue Shield, 205 Fed. App'x 652 (10th Cir. 2006) (No. 05-5214) ("HIPAA does not excuse a group health insurer from performance under a group health insurance plan when a covered employee inadvertently fails to disclose a preexisting medical condition or fails to fully disclose his or her medical history, because HIPAA, as a matter of legislative intent and public policy, requires that group health insurance coverage cannot be denied to a covered employee, or the employee's dependent(s), based on any pre-existing condition, medical history, etc."); *Hearings on Terminations 2009*, *supra* note 8, Preliminary Transcript at 137–38 (questioning of Karen Pollitz by Representative Deal) (Representative Deal asked, "[D]o you interpret that phrase ['continue in force'] to mean the non-cancellability that we have been talking about here, and if so, if that is what the [HIPAA] law that has been in place since 1996 means, why are we having this discussion?" Pollitz responded, "[W]ith respect to cancellation and rescission, I think Congress spoke to this in 1996 [in the HIPAA law]."). *But cf. Hearings on Terminations 2009*, *supra* note 8, Preliminary Transcript at 138–39 (testimony of Don Hamm, chief executive officer of Assurant Health) (stating that he did not "believe that rescission is considered nonrenewal" and outside of the realm of HIPAA requirements).

ing this HIPPA provision unenforceable in part because there is no express language that prohibits insurers right to rescind coverage when an insured makes a material misrepresentation.[178]

The failures of HIPAA are further highlighted by inconsistencies between state and HIPAA rescission standards. In recent case studies conducted by the Robert Wood Johnson Foundation, researchers compared insurance codes of four states—California, Texas, Connecticut, and Florida—with the HIPAA non renewability fraud standard.[179] In a final report, the researchers found that standards in all four codes contradicted HIPAA,[180] a conclusion that has been argued by others.[181] A particularly stark and common inconsistency between HIPAA's intentional fraud standard and state law is the presence of contestability periods. This is because contestability periods give insurers a period of time—ordinarily two years—to revoke coverage for any misrepresentation, regardless of whether the misrepresentation was intentional or unintentional.[182] HIPAA's guaranteed renewability provision, on the other hand, permits nonrenewal only in instances of fraud.[183] The consequence of contestability law periods is that the HIPAA fraud standard, which goes into effect upon issuance, seems to be in direct conflict with state law that allows revocations without fraud.[184] As one state regulator said, this means that insurers have a two-year period to conduct underwriting, during which time policyholders pay premiums but do not technically have coverage.[185]

The dissonance between HIPAA and state laws may be explained in part by a lack of state and federal regulation and oversight.[186] At a 2008 congressional hearing, Abby Block, the director of the Center for Drug and Health Plan Choice at the Centers of Medicare and Medicaid Services (CMS), stated that the "vast majority of [s]tates" are adequately enforcing HIPAA; interestingly enough, this

178. *See* Spencer v. Ark. Blue Cross & Blue Shield, 205 Fed. App'x. 652, 654 (10th Cir. 2006) (holding for the insurer despite the plaintiffs' argument that the rescission of their policy violated HIPAA's renewability guarantee); Riordan v. Golden Rule Ins. Co., No. 4:02-CV-60605-TJS, 2005 U.S. Dist. LEXIS 10673, at *17 (S.D. Iowa May 23, 2005) (stating there is nothing that indicates HIPAA eliminated the right of insurers to rescind coverage and the plaintiff did not provide any legislative history of HIPPA that demonstrates otherwise).

179. HARBAGE ET AL., *supra* note 112, at 7–8.

180. *E.g.*, one section of the Connecticut Code specifically mentions HIPAA's non renewal fraud exception; however, in another section, the Code would permit policies to be cancelled or rescinded if an application failed to contain information that would materially affect the risk accepted by the insured. *Id.* at 7. The difference between these provisions is that under the Code's latter provision, policies could be cancelled or rescinded for an applicant's unintentional omission of information, whereas under HIPAA such an action would be impermissible. *Id.*

181. *See Hearings on Terminations 2009*, *supra* note 8, Preliminary Transcript at 119–23 (statement of Karen Pollitz) (explaining that state laws, particularly contestability laws, may conflict with HIPAA's guaranteed renewability provision).

182. *See supra* text accompanying notes 112–16.

183. *See supra* text accompanying notes 175–76.

184. HARBAGE ET AL., *supra* note 112, at 7.

185. *Id.* (relying on information provided by Rick Wiseman from the Office of Insurance Commissioner Advocate, Florida Department of Financial Services).

186. While states have the primary authority to track and enforce HIPAA compliance, the Centers of Medicaid and Medicare Services (CMS) has the authority to oversee the insurance market if a state fails to "substantially enforce the requirements." *Hearings on Rescission of Policies 2008*, *supra* note 53 (statement by Abby Block, CMS Director of the Center for Drug and Health Plan Choice).

statement suggests that some states are not sufficiently enforcing requirements.[187] Later testimony by Block confirmed the federal government's minimal role in regulating and supporting state efforts to enforce HIPAA.[188] The absence of federal participation in the enforcement of HIPAA requirements, in conjunction with mismatched state and HIPAA laws may help explain the failed enforcement of HIPAA laws in the courtroom.[189]

To avoid a similar result under the newly enacted health reform legislation, courts should recognize the important role their decisions play in carrying out the will of Congress. Once congressional intent is apparent, courts should act as stringent enforcers of congressional intent, a component missing in courts' interpretation of HIPAA and their failed attempt to protect consumers.

Section 2712 of PPACA serves as a clear signal from Congress for courts to provide consumers added protection against rescission. In order to prove fraud, an insurer must be able to show that the adverse party not only made false statements, but also that he or she did so with fraudulent intent and acted with knowledge of the falsity of his or her statement.[190]

The failure of state laws to protect policyholders from undue rescissions also demonstrates the need for judicial enforcement. In 1993, the California Legislature passed an insurance law that prohibited insurers from rescinding policies except in cases of fraud or willful misrepresentation.[191] Notwithstanding the clear purpose and language of this provision, improper rescissions and coverage cancellations persisted.[192] In 2006, complaints of Blue Cross of California's systematic and nefarious methods in rescinding policies prompted the California Department of Insurance to investigate.[193] Two years later, the Los Angeles City Attorney prosecuted Blue Shield of California for false advertising and use of complex and confusing applications with the objective of rescinding expensive policies.[194] Subsequent investigations into California's five largest insurers resulted in eight rescission-related settlements between 2008 and 2009.[195] The settlements required insurers to

187. *Id.* Block subsequently testified that CMS has never found a state deficient in its enforcement of HIPAA. *Id.*

188. *Id.* According to Block, as of 2008 there were four "dedicated" staff to oversee the whole private market. HARBAGE ET AL., *supra* note 112, at 11. An absence of federal participation was confirmed by "Robert Wood Johnson researchers," who reported that none of the states in their four cases studies indicated that they received any support from the federal government. *Id.*

189. *See supra* text surrounding and accompanying note 178.

190. RUSS & SEGALL, *supra* note 43, § 31:82 (citing Maggini v. West Coast Life Ins. Co., 136 Cal. App. 472 (1934)).

191. CAL. HEALTH & SAFETY CODE § 1389.3 (Deering 2010).

192. *See infra* text accompanying note 195. The fact that there were eight rescission-related class action settlements between 2008 and 2009 provides virtually conclusive evidence that since Section 1389.3's enactment and 2009, health insurers successfully carried out improper rescissions.

193. In 2006, ten former policyholders sued the insurer for illegally cancelling their coverage shortly after expensive claims were filed. Lisa Giron, *Former Members Sue Blue Cross*, L.A. TIMES, Mar. 28, 2006, at C1.

194. Lisa Giron, *LA City Attorney Sues over Cancelled Polices*, L.A. TIMES, July 17, 2008, at C1.

195. HARBAGE ET AL., *supra* note 112, at 25. In one of the most recent settlements, the insurer Health Net agreed to reimburse class members for their expenses, absolve class members' bills, allow repurchase of coverage, adopt a corporate compliance program, enact a moratorium on rescissions, and stop giving employees bonuses for rescissions. Burtka, *supra* note 9, at 16. In a separate suit with California Hospital Association, Health Net agreed to pay the hospital association up to $14 million for services delivered to 800 patients whose coverage was improperly rescinded. Lisa Giron, *Insurance: Health Net Settles Suits on Rescission*, L.A. TIMES, Feb. 12, 2009, at C1. In another settlement, Anthem Blue Cross agreed to reverse 2,300 rescissions and pay a

change their internal practices for offering and rescinding coverage.[196] Section 1389.3 was passed in 1993, yet post-claims underwriting and improper recessions persisted until at least 2008, as demonstrated by these latest settlements. This persistence makes clear that enactment of laws by itself may not be enough to stem the tide of undue rescissions.

Recent success in California in stemming the number of rescission offers a good model for others to follow. For example, after the first round of litigation in 2006, the number of rescissions in California for the five largest managed care plans decreased substantially, from 1,536 in 2005 to 302 in 2006; this is despite the upward increase in the previous five years.[197] This trend—fewer rescissions with increased regulatory enforcement and litigation—appears to be true in Connecticut as well.[198] And in New Mexico, there is some indication that the enactment of a law in 2008 that limited rescission to cases of fraud or willful misrepresentation has caused the number of reported rescissions to decrease.[199]

C. Post-Claims Underwriting as Evidence of Insurers' Bad Faith Practices

The doctrine of bad faith in insurance law stems from contract law's implied promise of good faith and fair dealing.[200] There are two frameworks for bad claims that can be helpful in demonstrating the illegitimate practice of health insurance rescissions, even if a state lacks a statute that prohibits post-claims underwriting. The *Gruenberg* model—established by the California Supreme Court in *Gruenberg v. Aetna Ins. Co.*[201]—judges an insurer's actions by a standard of reasonableness.[202] Specifically, the *Gruenberg* paradigm asks whether a reasonable insurer under the same circumstances would have carried out the same claims practice that resulted in either the decision to deny or delay benefits.[203] In determining whether an insurer's action was reasonable, courts often look to standard insurance industry practices to determine whether a party's deviation from the standard is illustrative of bad faith.[204] Scholars and courts contend that post-claims underwriting is such a deviation.[205] This is because post-claims underwriting alters the traditional insur-

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fine of $15 million to the California Department of Insurance. Burtka, *supra* note 9, at 16. As of April 2010, suits against WellPoint and Blue Shield were still pending. *Id.*

196. Burtka, *supra* note 9, at 16. As a part of various settlements with insurers, California's regulatory bodies have been incorporating the requirements of the settlements into regulations for all insurers. HARBAGE ET AL., *supra* note 112, at 25–26.

197. According to the California Department of Managed Care, there were 882 rescissions in 2002, 743 in 2003, 1,436 in 2004, 1,536 in 2005, and 302 in 2006. HARBAGE ET AL., supra note 112, at 21 (these statistics may be accessed at http://info.sen.ca.gov/pub/09-10/bill/asm/ab_0001-0050/ab_2_cfa_20090427_115617_asm_comm.html) (last visited Dec. 29, 2010).

198. *See* HARBAGE ET AL., *supra* note 112, at 28 (stating that, once a stricter law to prevent rescissions took effect, the insurance department reported only three requests by insurers for rescission).

199. Statement from former attorney with the New Mexico Managed Health Care Bureau, Insurance Division, Public Regulation Commission (Mar. 24, 2011) (stating that "since the enactment of the new law, the Managed Health Care Bureau has not had any complaints regarding rescission that had reached the level of requiring my intervention as an attorney. Many, many rescissions still occur . . .").

200. *See supra* Part II.B.3.

201. 510 P.2d 1032 (Cal. 1973).

202. Cady & Gates, *supra* note 14, at 828.

203. *Id.*

204. *Id.* at 829.

205. *See, e.g.*, *id.* at 830 ("[P]ost claims underwriting is an unreasonable deviation from the standard industry practice of pre-issuance underwriting."); White v. Cont'l Gen. Ins. Co, 831 F. Supp. 1545, 1556 (D.

ance method of determining risk before issuance and amounts to a practice used to rescind and avoid paying benefits.[206] Thus, because post-claims underwriting alters the commercial standard of preissuance underwriting and is arguably intended as a means to avoid paying claims, post-claims underwriting fails the *Gruenberg* reasonable test.[207]

Post-claims underwriting also meets the *Anderson* requirements for bad faith, a model based on the Wisconsin Supreme Court decision in *Anderson v. Continental Ins. Co.*[208] The *Anderson* model is made up of two prongs: (1) "reasonableness" of the practice (this is the same reasonableness requirement from *Gruenberg*[209]), and (2) evidence that the insurer acted with "knowledge or reckless disregard of the lack of a reasonable basis for denying the claim."[210] Professors Thomas Cady and Georgia Gates contend that post-claims underwriting also satisfies the second prong because it takes advantage of the sequential nature of insurance contracts with the sole objective of purposefully delaying or denying benefits.[211] Having met the requirements for both the *Gruenburg* and *Anderson* tests for bad faith, Cady and Gates assert that post-claims underwriting is a practice that merits a per se rule of bad faith.[212]

Legislators and scholars have also spoken out against post-claims underwriting and in some states passed laws that ban or limit its use.[213] The connection between post-claims underwriting and rescission is particularly important in this regard. An insurer relies on post-claims underwriting to look "for all the things in an application that [it] might be able to dig up . . . to rescind the policy."[214] In essence, rescission and post-claims underwriting are inextricable, and therefore if one should be prohibited so should both. Thus because Section 2712 of PPACA prohibits rescissions except in cases of clear fraud, post-claims underwriting should also be uniformly prohibited.

D. Stopping Insurers from Using Rescission as a Remedy

In addition to finding that the practice of post-claims underwriting is per se bad faith, Cady and Gates also argue that the practice makes rescissions based on misrepresentation an unavailable remedy.[215] Relying on the Restatement Second of

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Wyo. 1993) ("[S]tandard industry practice is for the insurer to do a comprehensive investigation *before* agreeing to insure a person.").

206. Cady & Gates, *supra* note 14, at 830 (citing Nassen v. Nat'l States Ins. Co, 494 N.W.2d 231, 235 (Iowa 1992)).

207. *Id.*

208. 271 N.W. 2d 368, 376 (Wis. 1978).

209. Cady & Gates, *supra* note 14, at 829–31.

210. *Anderson*, 271 N.W.2d at 376.

211. Cady & Gates, *supra* note 14, at 831.

212. *Id.* at 830–31.

213. For example, states that prohibit post-claims underwriting include California, Colorado, Connecticut, Florida, Indiana, Maryland, New Hampshire, New Mexico, Ohio, Pennsylvania, Rhode Island, and Washington. PRIMER ON POST CLAIMS UNDERWRITING AND RESCISSION PRACTICES, *supra* note 11, at 7; *see also Hearings on Terminations 2009*, *supra* note 8, Preliminary Transcript, at 25 (statement of Rep. John Dingell) (describing "the rather vicious practice of post-claims underwriting and the detrimental effect that such practices have on hundreds of Americans").

214. Hailey v. Cal. Physicians' Serv., 69 Cal. Rptr. 3d 789, 799 (Cal. Ct. App. 2008) (citing Cady & Gates, *supra* note 14, at 813).

215. Cady & Gates, *supra* note 14, at 832.

Contracts, Cady and Gates highlight that rescission is an available remedy only if reliance on the misrepresentation is justified.[216] Interpreted differently, justified reliance implies that insurers act in good faith.[217] Thus, if an insurer relies on an applicant's misrepresentation because it did not know or discover the misrepresentation on account of its bad faith practices, the insurer is unjustified in rescinding the policy, even if the misrepresentation is committed intentionally.[218]

Health insurers use of and reliance on unusually brief and open-ended medical questions on application forms suggests that insurers may know that applicants fail to include all pertinent information in their responses.[219] Application questions tend to ask broad and non-specific questions about an applicant's medical history, making it easy and natural for an applicant to accidentally omit information.[220] The Eighth Circuit in *Werdehausen v. Benicorp Insurance Co.* explained:

> It is predictable in these circumstances that a certain number of employees will carelessly fail to disclose their relevant medical histories . . . particularly because the form provided a small blank space in which the applicant was asked to describe, for each prior treatment: "Details of medical conditions; treatment (past, current, and planned), medication (past, current and planned); degree of recovery and other helpful information."[221]

In the most recent congressional hearing on rescissions, rescinded policyholders highlighted the complexity and ambiguity of questions in their insurance applications.[222] Legislators have also noted consumers' complaints about the vagueness of

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216. *Id.* at 832–33.

217. *Id.* at 833 ("A recipient's fault in not knowing or discovering the facts before making the contract does not make his reliance unjustified *unless* it amounts in a failure to act in good faith and in accordance with reasonable standards of fair dealing." (emphasis added) (quoting RESTATEMENT (SECOND) OF CONTRACTS, § 172 (1981))).

218. *Id.* Post-claims underwriting deviates from standard commercial practices, a deviation that suggests bad faith. *See supra* note 205.

219. *See Hearings on Terminations 2009*, *supra* note 8, Testimony of Karen Pollitz, at 4 (discussing the vagueness of applications and the likelihood that consumers, especially those have health problems, will omit medical information).

220. *See id.* According to Pollitz,

> Underwriting questionnaires sometimes ask broad, vague, or confusing questions that may be difficult for consumers to answer accurately and completely. For example, the application might not ask specifically about high blood pressure, instead asking about 'cardiovascular' conditions, which might cause some people with low health literacy skills to misunderstand the question. Even if an application appears unusually "clean"—for example, one submitted by a 62-year-old indicating absolutely no health problems or health history—some insurers might accept that application and conduct no further investigation before coverage is issued, knowing that if a problem has been overlooked, it will be caught in a later post-claims investigation.

Id.; *see also* Nieto v. Blue Shield of Cal. Life & Health Ins. Co., 103 Cal. Rptr. 3d 906, 926 n.5 (Ct. App. 2010) ("[T]he Blue Shield application is far from a model of clarity, as the medical information checklist section of the application provides no separate answer spaces for each prospective insured.").

221. 487 F.3d 660, 666 (8th Cir. 2007).

222. For example, Jennifer Wittney Horton stated:

> Insurance companies require you to fill out an application that is deliberately confusing. And, they don't do anything to make sure you understood the questions, or that you supplied all the information they need to decide whether they want to insure you or not. . . .
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> . . . .

insurance applications and in some states taken steps to rectify the problem.[223] Such evidence demonstrates that insurers are aware that information provided in an insured's application may be incomplete. Consequently, insurers complete reliance on their insureds' application responses may be inappropriate.

Additionally, the brevity and speed of application approval may also demonstrate a business strategy by insurers to accept more applicants, and thereby increase revenue but decrease costs by simplifying the preissuance process.[224] While long and detailed applications are generally disliked, detailed forms can help the insurer screen undesirable risks.[225] Short application forms, on the other hand, gives the insurer less information to assess and accept risk.[226] With scant evidence of applicants' medical histories, insurers can accept more policyholders and premiums.[227] However, it is unfair to let an insurer make its applications short as a part of its business strategy and then rely on post-claims underwriting as a mechanism to hedge risk by avoiding the payment of expensive claims. The result of such a business decision by an insurer is that people are left uninsured at a time they need it the most. Such business decisions by an insurer "should not [make the insured] . . . [the] victim to the very same adverse risk an insurer was willing to embrace in the interest of profit and greed."[228]

E. Rescission of Health Insurance Policies Is Per Se Inequitable

Although rescission is intended to be an equitable remedy that returns parties to their status quo ante,[229] given the realities of the health insurance market a rescission will not restore an insured back to his or her prior condition. Today's health insurance market is marked by pervasive and inveterate discrimination against those with preexisting conditions; and as a result, a newly rescinded sick or injured person is virtually guaranteed to be denied new insurance or prohibitively

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> After being rescinded, I showed my original application to my sister and her husband, both radiologists, to ask them what I could have possibly done wrong in filling out the application. They felt that the application was worded in such a way as to be purposely confusing and that it asked the same question in multiple ways to trip people up. I am a college graduate, and "no dummy," and I still couldn't make sense of Blue Cross's tricky application.

Hearings on Terminations 2009, *supra* note 8, Testimony of Wittney Horton, at 49, 53.

223. California has proposed regulatory rules that require insurers to create applications that are "clear to average consumers, including questions 'designed to solicit accurate health history information' that cover 'reasonable time periods.'" HARBAGE ET AL., *supra* note 112, at 25; *see also Hearings on Terminations 2009*, *supra* note 8, Preliminary Transcript, at 93 (Comments made by Rep. Greg Walden) ("[S]eems to me that that is kind of the crux of the argument . . . [T]here are things that you didn't know that were on your medical records . . . I don't know [how] you ever disclaim knowledge of something you have no knowledge of . . . [T]o know as a layperson if you are on some medication years ago and you haven't been taking it, it would be easy to forget that. . . .").

224. Cady & Gates, *supra* note 14, at 823.

225. Gary Schuman, *Health and Life Insurance Applications: Their Role in the Claims Review Process*, 62 DEF. COUNS. J. 225, 243 (1995).

226. *See id.* at 226 (1995) ("[S]ome applications either limit the inquiries to whether the insured is now in 'good health' and/or has been diagnosed or treated for certain medical conditions within a specified time period. Or perhaps they don't ask good health questions at all.").

227. *See* Cady & Gates, *supra* note 14, at 823–24.

228. *Id.* at 824.

229. *See supra* Part I.D.

high premiums.[230] Moreover, it is unclear whether new laws in the recently enacted health reform legislation will sufficiently constrain such practices.[231]

Additionally, because an insurer has dealt with the insured as if he or she has coverage, the insured would not be looking for other sources of coverage before the applicant became sick or injured.[232] Rescission often occurs only when the insured is sick or injured and when no company will insure him or her.[233] If an insurance company conducts a thorough investigation before a policy is issued, it would discover a risk that it is unwilling to take and thus reject the applicant. And because the applicant is not yet sick or injured, he or she would have the possibility of being accepted by another insurer.[234] Thus once a person's policy is rescinded it is unlikely that he or she will be able to obtain similar health care coverage and the rescission will fail to restore the insured to his or her status quo ante.[235] Even if the new health reform law that bars insurers from denying insurance coverage based on preexisting condition goes into effect in 2014,[236] recently rescinded individuals may still face significantly higher premiums and never find another coverage plan with the same benefits and premiums that they could have obtained before being rescinded.[237]

The practice of rescinding health insurance policies also fails to achieve the goal of correcting unjust enrichment. When insurers rely on post-claims underwriting, they use rescission as a means to hedge risk by taking on more applicants and avoiding costly claims, thereby increasing sales and profits.[238] Thus, while an insurer increases its profits by its use of post-claims underwriting, an insured's risk of

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230. *See* Hailey v. Cal. Physicians' Serv., 69 Cal. Rptr. 3d 789, 799 (Cal. Ct. App. 2008) ("'[N]o company will insure an individual who had suffered serious illness or injury.'" (quoting Lewis v. Equity Nat'l Life Ins. Co., 637 So. 2d 183, 188–89 (Miss. 1994))). Thus, if the reasonable expectations of the insured are to be protected, the insurer must be required to conduct a full investigation before issuing a policy. Cady & Gates, *supra* note 14, at 858.

231. While new rules in the recently passed health reform legislation bar insurers from denying applicants based on preexisting conditions, they may not prohibit insurers from charging outlandishly high premiums. *See* Kevin Sack & Sheryl Gay Stolberg, *As Law Takes Effect, Obama Warns Insurers on Big Rate Increases*, N.Y. TIMES, June 22, 2010, at A13 ("The law does not grant the federal government new authority to regulate health care premiums, which remains the province of state insurance departments.").

232. *See* Cady & Gates, *supra* note 14, at 858.

233. *See id*. *But cf.* Brandt v. Time Ins. Co., 704 N.E.2d 843, 846–47 (Ill. App. Ct. 1998) (holding that the insured's failure to tell the insurer that he was a diabetic, and his subsequent diagnosis of stomach cancer, entitled the insurer to rescind the policy because the insurer has no duty to conduct an independent investigation before issuing a policy).

234. Cady & Gates, *supra* note 14, at 858.

235. *See Hailey*, 69 Cal. Rptr. 3d at 802 (stating that the rescission of Hailey's policy left unpaid medical bills and a new preexisting condition that limited his ability to receive necessary health care, and that "[i]t is impossible to return the Hailey's to the 'status quo' under any definition of the term").

236. Julie Appleby, *Changes Coming to Insurance Plans*, KAISER HEALTH NEWS, Apr. 6, 2010, http://www.kaiserhealthnews.org/Stories/2010/April/06/Changes-Coming-To-Insurance-Plans.aspx (last visited Dec. 29, 2010).

237. Even though various provisions of the new health reform law restrict insurers ability to increase premiums, there is still much debate on whether such provisions will be effective, and if so, what effect they will have on premiums overall. *Id.* Additionally, many of the provisions that restrict premium increases will not go into effect until 2014, leaving a considerable amount of time for insurers to continue charging prohibitively high premiums. *See id.*

238. *See supra* text accompanying notes 226–28 (discussing insurers' marketing decision to accept more applicants and collect more money in premiums); Cady & Gates, *supra* note 14, at 824 ("[A]n insurer relies upon post claim underwriting to avoid the consequences of its reasoned marketing decisions to forgo underwriting . . . to increase sales and, concomitantly, profits.").

rescission increases, producing an imbalance between risk and reward tilted toward the insurer. As a result, rescissions appear to actually foster the unjust enrichment of insurers.

The physical costs that rescission can have on a sick or injured person also highlight the inequity of such a remedy. In prohibiting post-claims underwriting, the California Legislature's "unmistakable purpose" was to "prevent the unexpected cancelation of health care coverage at a time that coverage is needed most."[239] The recognition by California's Legislature of the heightened need of insurance when a person is sick illuminates the physical cost a rescission can have. Robin Beaton's testimony at a 2009 congressional hearing about her experience being rescinded is a good example. Diagnosed with a severe type of breast cancer and scheduled to undergo a double mastectomy, Beaton was informed by her insurer, Blue Cross and Blue Shield, three days before her operation that her file had been "red flagged."[240] The red flag initiated an investigation into Beaton's previous five-year medical history, which ended in Beaton's insurance policy being rescinded.[241] Unable to pay for the operation herself, Beaton did not have the operation as planned.[242] Though Beaton's policy was eventually reinstated, in part due to the intervention of her congressman, her tumors had grown and likely worsened her prognosis. Thus, Beaton was left in a worse health condition than had her policy not been rescinded and certainly a worse health condition than before her insurance contract was issued.

Beaton's experience is not an isolated occurrence, as insurers commonly red flag expensive claims, such as cancer, and initiate similar intensive investigations into an insured's medical history.[243] As a result, those with expensive and possibly fatal health conditions are more likely to undergo a post-claims investigation and have a greater chance of their policy being rescinded.

F. Casting Doubt on Insurers' Justifications of Rescission

As health care expenses soar, insurers, legislators, policymakers, and consumers seek ways to contain costs. One commonly cited reason to employ rescissions is that it is an effective means to combat fraud.[244] Insurers maintain that rescission and post-claims underwriting are business practices that help decrease costs[245] and

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239. *Hailey*, 69 Cal. Rptr. 3d at 800–801. The Chairman of the Senate Committee on Insurance, Claims, and Corporations stated "it is often said in this country that insurance is only for the healthy. SB 590 is designed to make sure that insurance is available when you need it the most." *Id.* at 801 n.5.

240. *Hearings on Terminations 2009*, *supra* note 8, Preliminary Transcript, at 63 (Statement by Robin Beaton, rescinded policyholder). Beaton applied and received an individual health plan in May 2007. *Id.* In May 2008, she went to a dermatologist for acne; her doctor wrote on her file that the acne may be considered precancerous. *Id.* Her dermatologist's note initiated an investigation into Beaton's previous five-year medical history, requiring Beaton to submit pharmacy reports, doctors' records, and any medical documents. *Id.*

241. *Id.*

242. *Id.* at 63–64.

243. *See* Burtka, *supra* note 9, at 16 (explaining that insurers are known to intently screen expensive claims such as leukemia, breast cancer, diabetes, bronchitis, or pregnancy with twins).

244. Zalma, *supra* note 75, at 204.

245. *See, e.g.*, *Hearings on Terminations 2009*, *supra* note 8, Preliminary Transcript, at 113–14 (Statement of Brian Sassi, President and Chief Executive Officer, Consumer Business, WellPoint Inc.) ("I want to emphasize that rescission is about stopping fraud and material misrepresentation that contribute to spiraling health care costs. . .If we fail to address fraud and material misrepresentation, the cost of coverage would increase, making coverage less affordable for existing and future individual policyholders.").

occur infrequently, in less than one percent of policies.[246] Thus, in addition to combating fraud, insurers' basis for using post-claims underwriting and rescission is economic efficiency, as both practices save money for the insurer and presumably reduce costs for the consumer.[247]

Yet, it is debatable whether economic efficiency should eclipse the principles that underlie an equitable remedy.[248] While courts may be influenced by the principle of economic efficiency, some values are more important.[249] The well-known contracts case of *Wangen v. Ford Motor Co.* is a good example.[250] In this case, the court held that a manufacturer's purposefully calculated cost-benefit decision to pay damages rather than repair a defective fuel tank was a decision likely to lead to unnecessary deaths.[251] Thus, the court held that the manufacturer's decision could be punished with a large punitive damage award, even if that award was not economically efficient.[252] Similarly, an insurer's decision to avoid a thorough pre-issuance medical underwriting process for economic efficiency reasons unnecessarily increases a policyholder's risk of rescission and leaves sick policyholders uninsured at a time their health and physical wellbeing is most at risk. Like *Wangen*, this decision by insurers endangers policyholders' lives, and courts should not accept economic efficiency as a justification for insurers use of post-claims underwriting.

Though rescission may affect few policyholders compared to the entire number of people holding policies—according to insurers, roughly less than one percent—this statistic may be misleading. Karen Pollitz, a policy researcher at Georgetown University, points out that one percent of the population accounts for one-quarter of all medical bills.[253] Thus, it is likely a substantial number of policyholders who never submit a claim or submit fairly inexpensive claims will never be subject to post-claims underwriting and therefore never face the risk of a rescission. As a result, the true proportion of policyholders who could be subject to a rescission is probably more than the 0.1% insurers allege. However, even if the number of rescissions is as small as insurers allege, these policyholders "are the [people] most vulnerable and most in need of coverage."[254]

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246. *Id.* at 3 (Statement of Brian A. Sassi) (stating that in 2008 WellPoint enrolled "approximately 873,000 new individual market members and rescinded 1,275 contracts, approximately one tenth of a percent [0.1%] of the new enrollment"). Notwithstanding this estimate, health policy researcher Karen Pollitz points out that one percent of the population accounts for one-quarter of all medical bills: "The sickest individuals may be small in number, but they are the most vulnerable and most in need of coverage." *Id.* at 5 (Statement of Karen Pollitz).

247. *See* N.Y.Life Ins. Co. v. Johnson, 923 F.2d 279, 284 (3d Cir. 1991) (discussing that the victims in fraudulently obtained policies are the honest applicants who tell the truth and whose premiums will rise over the long term).

248. *See, e.g.*, Leonard E. Gross, *Objective of Remedies: Damages, Equity, and Restitution*, 39 BRANDEIS L.J. 529, 530 (2001) (stating that in some cases a court may decide that some values are more important than economic efficiency); Hailey v. Cal. Physicians' Serv., 69 Cal. Rptr. 3d 789, 807 (Cal. Ct. App. 2008) (stating that "[u]doubtedly an insurance company is . . . [permitted] to pur[sue] its own economic interests . . . [but] the exercise of the privilege . . . must be done in a permissible way and with a good faith belief in the existence of the rights asserted.") (citation omitted).

249. Gross, *supra* note 248, at 530.

250. 294 N.W.2d 437 (Wis. 1980).

251. Gross, *supra* note 248, at 530.

252. *Id.*

253. *Hearings on Terminations 2009*, *supra* note 8, at 5 (Statement of Karen Pollitz).

254. *Id.*

Moreover, there may be a broader duty of loyalty imposed by the fiduciary relationship that obligates insurers to avoid rescissions and seek other means to remedy an alleged misrepresentation.[255] Relying on this duty, the Eighth Circuit in *Werdehausen* found the insurer was acting under a conflict of interest when it decided to rescind Werdehausen's policy.[256] The reasoning in *Werdehausen* may be extended to other situations. For example, once an insurer discovers a policyholder's alleged misrepresentation the insurer is faced with a number of options it can take to rectify the misrepresentation: rescission, maintain the policy and retroactively increase the premium to account for the newly discovered risk, or continue the policy in force while the insured receives treatment, following which the insurer can initiate a process to recoup possible losses for the misrepresentation. Out of these options, rescission likely saves the insurer the most money, but it is the most unfairly punitive to the insured.

While in *Werdehausen* the insured's policy contract explicitly provided for retroactively increasing the premium, the court's reasoning should be extended to situations without such a policy provision. The fiduciary duty of loyalty and its corollary responsibility to act in the interest of beneficiaries should guide an insurer's decision-making. There are numerous remedial actions an insurer can take with respect to rectifying a material misrepresentation and the express presence of such a provision, should not be dispositive of whether an insurer acted in accord with its fiduciary duty or in good faith. Consequently, insurers should make decisions that prevent or mitigate physical and emotional harm to their beneficiaries,[257] irrespective of the presence or absence of a contract provision that provide otherwise.

CONCLUSION

A majority of Americans receive their health insurance from the private market, either from their employer or through the purchase of a plan in the individual market. Employer-sponsored plans are regulated almost entirely by ERISA, with a few exceptions. While ERISA's preemptive power over state laws is broad, ERISA imposes a fiduciary relationship that encompasses a duty of loyalty to plan participants and beneficiaries. Whether plans bought in the individual market impose a fiduciary duty on the insurer depends on the jurisdiction; a significant number of jurisdictions do.

Unlike traditional underwriting, which conducts a thorough examination of applicants' medical histories prior to the issuance of a policy, post-claims underwriting deviates from this traditional practice. Legislators and legal scholars contend that this deviation raises the inference of insurers' improper motives and bad faith practices; some states have even outlawed the practice. Moreover, evidence from insurers' application methods and failure to conduct a thorough underwriting process demonstrates that insurers strategically create confusing medical question-

255. *See supra* text accompanying notes 93–96 (discussing ERISA insurer's duty of loyalty to their insureds).

256. *See supra* text accompanying notes 166–69.

257. *See, e.g.*, *supra* text accompanying notes 240–43 (telling Robin Beaton's story). Beaton's insurer's rescission forced her to forgo a double mastectomy, and as she waited for her insurance to be reinstated, her tumors grew. *Id.* The insurer's decision to rescind, rather than retroactively increase premiums or maintain her policy and later recoup losses, put Ms. Beaton in considerable, possibly fatal, danger of harm. *Id.*

naires and rely on post-claims underwriting to enroll as many applicants as possible. Thereby insurers avoid risk by rescinding policies if applicants incur expensive medical costs. Courts have continued to allow insurers to carryout these practices, even though the remedy of rescission fails to produce the most equitable result. This is because rescinded health insurance policyholders can never be restored to their status quo ante.

Congress had made it clear that it seeks to limit insurers use of rescission to the clearest cases of fraud. Other federal and state legislation failed to prevent undue rescission. The new health care reform law should give courts and litigants the impetus to play a greater role in preventing such practices.