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## **Post-Claim Underwriting: Calif.'s Dirty Secret**

*Law360, New York (August 14, 2009)* -- Millions across the nation try to protect themselves from the “what ifs” and take steps to make the right decision to have health insurance. They seek out a reputable insurance company, pay the premiums on time, and schedule annual check-ups. They have protected themselves and their family. But, have they done enough?

Across the country, patients are filing lawsuits against insurance companies for canceling health insurance policies and refusing to pay medical bills.

The lawsuits allege that insurance companies are trying to avoid paying legitimate claims by canceling policies after an insured makes a claim, pointing to a wrong or incomplete answer in the patient’s application for insurance.

To attract consumers, insurance companies have simplified the process by streamlining the application process and approving consumers with only the information contained in the application.

Insurance companies are weighing their duty to investigate a consumer’s background before issuing coverage against the time, resources and money involved. They are resorting to post-claim underwriting.

For example, suppose that like millions, you have purchased an individual health plan. You seek out a reputable insurance company and apply. Your application gets immediately approved, you pay your premiums on time and schedule annual check-ups.

Now imagine that months, even years later, you have been diagnosed with a form of brain cancer. Thinking that you have adequately protected yourself from the “what ifs” in life, you turn to your health insurance company for assistance in your time of need. That is the first time you submit a big claim to your company.

However, coverage is denied and your policy is retroactively rescinded based on the fact that you made a material misrepresentation regarding your health on your policy application.

The health insurance company claims that the headaches you complained about months before you applied for policy should have been listed on your application. Had that headache been listed, you would have been denied coverage because of the future cancer. Absurd? Not really, this scenario is more common than you think!

Michael Norris knows all too well the world of post-claims underwriting. Mr. Norris enrolled his son Kyle, 4 at the time, in a Blue Cross Insurance plan in December 2004. On June 13, 2005, Kyle underwent a preapproved surgery to remove a mass of tissue at the back of his throat that could restrict breathing (adenoidectomy).

Blue Cross eventually rescinded Kyle's health insurance and has refused to pay \$15,000 in medical bills. Blue Cross claims that Mr. Norris failed to disclose his son's earaches and speech impediment on the enrollment form.

In a similar situation, Blue Shield dropped Steve Hailey's coverage after a car accident left him with more than \$400,000 in medical bills. His wife, Cindy Hailey, filled out his application and failed to list that he had pre-existing conditions of high blood pressure and chest pains.

Recently in a directed verdict in the middle of trial, Orange County Superior Court Judge Peter Polos found that Blue Shield acted in good faith when the company investigated the medical history of Steve Hailey and dropped his policy.

Even though Hailey was not victorious, his case helped prompt state regulators to target questionable health insurance rescissions. More than \$13 million in fines for rescissions have been collected from Anthem, Blue Cross, Health Net Inc., PacifiCare, Kaiser Permanente and Blue Shield.

There are a number of lawsuits on state dockets alleging health insurers dropped coverage after policyholders made pricey claims. However, the problems with post-claims underwriting are not limited to health insurance.

### **Underwriting Practice, Generally**

"Underwriting" is the process, fundamental to insurance, of deciding which risks to insure and which to reject in order to spread losses over risks in an economically feasible way.

Insurance underwriters evaluate the risk and exposures of the prospective clients. They decide how much coverage an applicant should receive, how much they should pay for it, or whether to even accept the risk and insure them.

Underwriting involves measuring risk exposure and determining the premium that needs to be charged to insure that risk. The function of the underwriter is to acquire or to "write" business that will make the insurance company money, and to protect the company's book of business from risks that they feel will make a loss. In simple terms, it is the process of issuing insurance policies.

Each insurance company has its own set of underwriting guidelines to help the underwriter determine whether or not the company should accept the risk.

The underwriters can either decline the risk or may decide to provide a quotation in which the premiums have been loaded, or in which various exclusions have been stipulated, which restrict the circumstances under which a claim would be paid.

Depending on the type of insurance product (line of business) insurance companies use automated underwriting systems to encode these rules and reduce the amount of manual work in processing quotations and policy issuance.

This is especially the case for certain simpler life or personal lines (auto, homeowners) insurance. For more complex risk (for example industrial or commercial property or casualty, engineering or marine insurance) individual, case by case underwriting is usually required to evaluate the risk.

Typically, the underwriting is conducted prior to the issuance of the policy. But, that is not always the case.

### **What Is Post-Claims Underwriting?**

Due to the large number of policies that an insurance company is typically asked to sell, insurance companies are usually not able to undertake an independent investigation of a prospective insured before issuing a policy.

Post-claims underwriting is the process that has been described as insurance companies asking an applicant for information and issuing a policy based on the responses without undertaking any independent investigation of the applicant's history.

A claim is subsequently submitted, and only then does the insurance company investigate the policyholder's prior history by requesting additional information to see whether the policyholder actually qualified for coverage at the time it was purchased.

Then, should it be determined the policyholder made a material misrepresentation, coverage is cancelled retroactively.

This investigation was done, not at the time of issuance of the coverage, but after the policy had been issued, after substantial premiums had been collected, and after a claim for benefits had been submitted by the policyholder.

In other words, it was not performed when the applicant completed and submitted a detailed history questionnaire and before the coverage was placed.

### **Can a Policy be Cancelled if Post-Claims Underwriting is Utilized?**

Generally, the duty to provide insurance is strictly a matter of contract law. Absent an agreed or implied contractual provision, there is no duty to insure. An application for insurance is an offer that, like any other offer, does not become a contract until accepted by the insurance company.

No insurance company can be required to provide insurance coverage to every applicant who seeks coverage. The power of acceptance lies with the insurance company, and without its acceptance, no valid contract exists.

Once insurance is issued, however, there are specific rules in place governing an insurer's ability to cancel coverage should it discover false answers in the application.

California law routinely recognizes that, in order to justify a rescission (i.e. cancellation) of an insurance policy on the basis of a "material misrepresentation" or "material concealment," the insurance company must prove that the prospective applicant had an "actual intent to deceive" when he/she applied for coverage.

The California Supreme Court found that if an applicant for insurance had "... no present knowledge of the facts sought, or failed to appreciate the significance of information related to him, his incorrect or incomplete responses would not constitute grounds for rescission." This is still the law in California.

Section 1389.3 of the Health & Safety Code of California, was specifically put on the statutory books to prohibit post-claims underwriting:

"Post-claims underwriting prohibited:

"No health care service plan shall engage in the practice of post-claims underwriting. For purposes of this section, 'post-claims underwriting' means the rescinding, canceling or limiting of a plan contract due to the plan's failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the plan contract. This section shall not limit a plan's remedies upon a showing of willful misrepresentation."

A misrepresentation in an insurance application is an untrue statement or fact. Incomplete answers or a failure to disclose material information on an application for insurance may also constitute a misrepresentation.

However, a misrepresentation alone is not by itself grounds for denial of coverage. The "materiality" of the misrepresentation must be established. The question of materiality is

determined by the extent to which the false answer influenced the insurance company to assume the risk of coverage.

Generally, if the insurance company with knowledge of the true facts would have denied a policy or would have issued one under different terms from that which it did issue, the test of materiality has been satisfied. When a misrepresentation is material it deprives the insurance company of its freedom of choice in determining whether to accept the risk.

If the information given by the applicant is false, but the insurance company would have issued the same policy regardless, then it is not material. Consequently, the question of materiality is determined at the time the policy was issued.

Materiality often is a question of fact but, in the appropriate situation, may become a question of law.

In most cases the proof offered by the insurance company consists of testimony or affidavits by company underwriting personnel, or the medical director, as to what the company would have done had it had all the facts, supplemented, in some cases, by portions of the company's underwriting manual.

The third element is that, at the time the policy was issued, the insurance company reasonably relied on the representation made by the applicant.

An insurance company cannot avoid liability on a policy if it can be shown the insurance company did not actually rely on the applicant's misrepresentation.

This failure of reliance can be established if the insurance company had actual knowledge of the true facts, or at least a sufficient indication that would have put a prudent person on notice.

This may preclude the insurance company from rescinding its contract if it disregarded that notice and did not make reasonable inquiries to confirm or refute those indications.

Similarly, when an applicant gives sufficient information to alert an insurance company to his/her particular medical condition or history, the insurance company then becomes obligated to make such further inquiry as is reasonable under the circumstances in order to ascertain the facts surrounding the information given.

The question of what constitutes "sufficient indications" is ordinarily one for the trier of fact.

The mere fact that the insurance company conducts an independent investigation does not, by itself, indicate a lack of reliance.

This is true unless the investigation discloses facts sufficient to expose the falsity of the representations of the applicant or facts that are of such a nature as to place upon the insurance company the duty of further inquiry, but the insurance company decides to issue the policy anyway.

Many courts hold that a material misrepresentation alone, even if innocent, voids the contract. Some state statutes and courts require that an insurance company seeking to avoid a policy on the basis of misrepresentation also show fraud by the applicant.

Intent to deceive may involve either the policyholder's knowledge of the falsity of the statement and its materiality to the risk or circumstances in which the policyholder must have known the statement to be material to the risk.

Several states have statutes that require that the facts misrepresented must contribute to the actual loss. In these states, the law imposes a far greater burden on an insurance company than that imposed at common law.

Questions on the application also raise the issue of ambiguity. An answer to an ambiguous question will not support a misrepresentation defense when a person could reasonably interpret a question as the applicant did. Ambiguities must be interpreted against the insurance company.

When the insurance company asks clear and unambiguous questions, the duty rests with the policyholder to furnish truthful, accurate and complete responses in order to allow the insurance company to adequately evaluate any risks revealed.

Questions that request specific information regarding medical history and that do not call for the applicant to interpret technical medical terminology but rather are written in everyday language that a layperson should be able to understand have been held to be clear and unambiguous.

The duty of the insurance company to a policyholder is especially important when the insurance company rescinds coverage.

In this situation, the policyholder is not merely at the mercy of the insurance company to be treated fairly in the processing of a single claim, but must rely on the insurance company's good faith for the continued existence of any coverage.

Forfeiture of an insurance policy is strongly disfavored, especially when the event that gives rise to the insurance company's liability has already occurred.

Not only is the policyholder prevented from recovering on the claim at issue, but also, such as when health insurance is involved, may be precluded from obtaining other coverage.

Courts attempt to prevent an insurance company from taking advantage and failing to honor the reasonable expectations of policyholders and intended beneficiaries.

Those challenging the practice of post-claim underwriting take the position that any misrepresentations contained in the application are excused because the insurance company is fully capable of obtaining whatever facts it needs before it decides to issue coverage.

If a policyholder is not an acceptable risk, the application should be denied immediately, not after the policy is issued. The burden of investigating and ascertaining the facts affecting the applicant's insurability should fall on the insurance company.

The insurance company should not be allowed to deny benefits to the policyholder or beneficiary on the basis of information which, if it had been more careful to investigate, the insurance company could have obtained before issuing the policy.

The insurance company that refuses to investigate until after a claim is filed, runs the risk that it has insured a policyholder it otherwise would not have.

--By Lourdes DeArmas, Khorrami Pollard & Abir LLP

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