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A HEALTHY STATE OF MIND: THE ROLE OF INTENT IN HEALTH CARE SERVICE PLAN RESCISSIONS

*Gerald S. Flanagan**

*Under California law, a health care service plan ("health plan") may use an individual applicant's health condition as a consideration when determining whether to sell the applicant a coverage policy. A health plan can refuse to provide coverage even if an applicant has only minor health problems. Previously, the California Department of Managed Health Care (DMHC) prohibited a health plan from rescinding a coverage policy unless a patient had willfully misrepresented her health information during the application process. However, following dicta in a recent California Court of Appeal decision, the DMHC now apparently affirms rescissions that are based on patients' failure to disclose health information regardless of whether the alleged omissions or misrepresentations were intentional, willful, or knowing. In *Hailey v. California Physicians' Service*, the court noted that a health plan may rescind coverage based on an inadvertent omission or misrepresentation, including health conditions that a patient did not know about or did not understand, as long as the court finds that the health plan made a "reasonable effort" to determine whether the application was complete at the time it was submitted. The DMHC's overly broad interpretation of *Hailey* conflicts with California Supreme Court precedent that protects innocent patients from rescission who have coverage provided by health insurance companies, which are governed by a legislative and regulatory regime that is distinct from that of health plans. The DMHC's tacit approval of this practice by health plans places innocent patients at risk of losing coverage when they get sick and need it the most.*

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I. INTRODUCTION

Imagine you are diagnosed with a serious illness. Luckily, you have health care coverage. Or do you? You may not, according to California regulators, if you unintentionally omitted a medical detail when you applied for coverage. In a dramatic reversal of policy, regulators at the California Department of Managed Health Care (DMHC)¹ have apparently affirmed the health care service plan (“health plan”) practice of rescinding individual health coverage contracts on the basis of inadvertent omissions by applicants in their applications for coverage.² Previously, the DMHC’s policies and official statements acknowledged that rescission must be limited to cases of willful misrepresentation by the applicant.³ The DMHC regulators’ new view of the law of health coverage rescission relies

1. The DMHC is responsible for regulating health care service plans, including health maintenance organizations (HMOs) and some preferred provider organizations (PPOs), under California Health and Safety Code sections 1340–1399.970 (“Knox-Keene Health Care Service Plan Act of 1975”). The Department of Insurance regulates health insurers. J. CLARK KELSO, CAPITAL CTR. FOR GOV’T LAW & POLICY AT UNIV. OF THE PAC. MCGEORGE SCH. OF LAW, REGULATORY JURISDICTION OVER HEALTH INSURANCE PRODUCTS: THE DEPARTMENT OF MANAGED HEALTH CARE & THE DEPARTMENT OF INSURANCE 5–15 (2001). Approximately 22 million Californians receive health coverage from companies regulated by the DMHC. *Id.* The director of the DMHC is appointed by the governor of California. *Id.* The DMHC is a subdepartment of the State of California Business, Transportation and Housing Agency. *Id.*

2. *Business Practices in the Individual Health Insurance Market: Hearing Before the H. Comm. on Oversight and Government Reform*, 110th Cong. 3 (2008) (prepared statement of Dale Bonner, Sec’y Cal. Bus., Transp. and Hous. Agency) [hereinafter *Hearing*] (“Current law states that the ‘insurer must either complete medical underwriting up front or show that the enrollee willfully omitted or misrepresented information on the application.’”).

3. Amicus Curiae Brief by the California Dep’t of Managed Health Care in Support of Plaintiffs, Cross-Defendants, and Appellants at 4, *Hailey v. Cal. Physicians’ Serv.*, 69 Cal. Rptr. 3d 789 (Ct. App. 2007) (No. G035579) [hereinafter *DMHC Amicus*] (“Because of the catastrophic consequences of losing health care coverage, and in furtherance of the consumer protection purpose of the Knox-Keene Act, the Legislature enacted section 1389.3 . . . [which] allows a health plan to rescind coverage only in cases where it has met its burden of demonstrating that the consumer willfully misrepresented his or her health history.” (emphasis added)); *id.* at 14 (“[S]ection 1389.3 . . . requires health plans to demonstrate that an applicant willfully misrepresented his or her health history before invoking other remedies such as rescission. That requirement exists in all cases, not just those where the plan failed to resolve all reasonable questions arising from the information submitted on or with the application.” (emphasis added)); see also DIV. OF PLAN SURVEYS, DEP’T OF MANAGED HEALTH CARE, NON-ROUTINE MEDICAL SURVEY OF BLUE CROSS OF CALIFORNIA 3 (2007) [hereinafter *DMHC AUDIT*] (finding that Blue Cross of California routinely rescinded health policies in violation of state law by failing to establish that an enrollee willfully misrepresented a health condition); Lisa Girion, *Health Plan Review May Be Intensified*, L.A. TIMES, Jan. 30, 2007, at D1 (paraphrasing DMHC director Cindy Ehnes’s statement that the “law banned retroactive rescissions unless a health plan could show that a policyholder intentionally lied about his health history on his application for coverage”).

on dicta in a recent California Court of Appeal decision, *Hailey v. California Physicians' Service*.⁴ The regulators' overbroad reading of *Hailey* puts an innocent patient at risk of losing coverage when she gets sick and needs it the most if she failed to report medical information *that she was not even aware of or did not understand* when she applied for coverage.

State, national, and international news reports⁵ tell the stories of some of the thousands of Californians and their families who have faced health coverage rescissions since 2004.⁶ A patient whose health coverage is rescinded ("rescinded patient") is left uninsured, likely uninsurable,⁷ and often deep in medical debt while facing ongoing health care needs.⁸ In a typical example,⁹ after a patient files a major claim for health coverage, such as cancer treatment,¹⁰ the health plan scrutinizes the patient's medical record and compares it to the information the patient provided in her application for coverage, looking for any "omitted" or "misrepresented" information.¹¹ If the health plan finds any information that it deems "omitted" or "misrepresented," the health plan then rescinds coverage even if the patient innocently failed to disclose minor health information on the application. For example, a health plan rescinded a patient's policy for the patient's failure to disclose a single back spasm that the patient experienced years before

4. 69 Cal. Rptr. 3d 789 (Ct. App. 2007).

5. Consumer Watchdog, Archive of News Coverage, <http://www.consumerwatchdog.org> (search for "rescission") (last visited Feb. 7, 2010).

6. Lisa Girion, *Anthem Blue Cross Sued Over Rescissions*, L.A. TIMES, Apr. 17, 2008, at C1.

7. See discussion *infra* Part III.C.

8. David U. Himmelstein et. al., *Marketwatch: Illness and Injury as Contributors to Bankruptcy*, HEALTH AFFAIRS, Feb. 2, 2005, <http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.63/DC1> (finding that nearly half of all Americans who file for bankruptcy do so because of medical expenses).

9. The example is based on hundreds of complaints reviewed by the author.

10. Lisa Girion, *Sick but Insured? Think Again*, L.A. TIMES, Sept. 17, 2006, at A1 (reporting that Blue Cross designated an entire department inside the company that, upon receiving patients' high-dollar-value insurance claims, reviews medical records and investigates a patient's insurance risk).

11. Refiled Motion for Judicial Notice of Shernoff, Bidart & Darras, LLP, at Exhibit A, B & C, *Hailey v. Cal. Physicians' Serv.*, 69 Cal. Rptr. 3d 789 (Ct. App. 2007) (No. G035579) [hereinafter Shernoff Motion] (relating testimony from Blue Shield employees stating that prior to rescinding a policy the company did not attempt to determine whether omissions on applications constituted a "willful misrepresentation").

completing the application.¹² Health plans are known to take such action regardless of whether the patient knew of the information the health plan alleges was omitted.¹³

DMHC regulators interpret the *Hailey*¹⁴ decision as allowing health plans to rescind a patient's coverage for failing to disclose health information regardless of the patient's state of mind when she applied for coverage—regardless of whether the alleged omission or misrepresentation was intentional, willful, or knowing.¹⁵ The regulators' interpretation conflicts with California Supreme Court precedent that protects innocent patients from rescission who have coverage provided by *health insurance* companies—which are governed by a legislative and regulatory regime that is distinct from that of health plans.¹⁶ Because of heavy lobbying by health plans,¹⁷ California Governor Arnold Schwarzenegger vetoed bipartisan legislation designed to remedy this apparent conflict in the law of rescission governing health plans and health insurers.¹⁸

California consumers face a confusing alphabet soup of health coverage options to choose from: HMO, PPO, EPO, and POS to name a few.¹⁹ There is often little apparent difference to consumers and courts between two broad groupings of coverage, which are largely distinguished by the type of company that sells it—health plans and health insurance companies.²⁰ However, the two groups are regulated by distinct regulatory agencies and separate legal

12. See Complaint at 4, *Knee v. Blue Cross of Cal.*, No. BC389440 (Cal. Super. Ct. 2008).

13. Shernoff Motion, *supra* note 11, at Exhibit A, B & C.

14. 69 Cal. Rptr. 3d 789 (Ct. App. 2007).

15. *Id.*

16. See *Thompson v. Occidental Life Ins. Co.*, 513 P.2d 353, 360 (Cal. 1973); *Runyan v. Pacifica Air Indus., Inc.*, 466 P.2d 682, 691 (Cal. 1970).

17. On numerous occasions prior to vetoing the legislation, including in his 2008 State of the State address, Governor Schwarzenegger pledged to protect innocent patients from rescission. *E.g.*, Lisa Girion, *Bonuses for Cutting Coverage is Banned*, L.A. TIMES, July 23, 2008, at C3 (“Until we achieve comprehensive healthcare reform, stopping unfair healthcare rescissions is an urgently needed consumer protection”); Lisa Girion, *State Fines 2 Health Plans Over Canceled Coverage*, L.A. TIMES, July 18, 2008, at A1; Dorsey Griffith, *Patients Get a Victory as State Restores Insurance for Some, Orders Reviews for Thousands*, SACRAMENTO BEE, April 18, 2008, at A1 (“[It is] outrageous that innocent patients have to live in fear of losing their health care coverage. I look forward to working with my partners in the Legislature to ensure this egregious practice is stopped.”).

18. Editorial, *Schwarzenegger Abandons the Sick*, L.A. TIMES, Oct. 4, 2008, at A20.

19. See KELSO, *supra* note 1, at 1–2.

20. *Id.* at 7.

codes: the Department of Insurance and the Insurance Code govern health insurers, whereas the Department of Managed Health Care and the Health and Safety Code govern health plans.²¹ Additionally, some companies have subsidiaries licensed by both departments, which adds to the complexity that confronts consumers.²² California's bifurcated regulatory approach adds up to an unfortunate truth for consumers: what you do not know can hurt you.

This Note argues that either proposed but currently shelved regulations clarifying the legal standard for health plan rescissions should be implemented,²³ or new legislation or court action should be implemented to bring health plan rescissions in line with the California Supreme Court fairness doctrine that applies to health insurance companies. Without at least one of these changes, Californians will continue to face a form of "health care apartheid." Innocent patients enrolled in health plan coverage will continue to be at risk of having their coverage rescinded when they get sick and need health care the most, while those enrolled in health insurance coverage will enjoy a higher level of protection.²⁴ Part II of this Note discusses California law applying to health plan coverage rescissions. Part III explores the threats facing innocent health plan patients under the DMHC regulators' overbroad reading of *Hailey*, and the divergent Supreme Court precedent that applies to health insurance companies. Finally, Part IV proposes solutions to close the apparent conflict by protecting *all* innocent patients from coverage rescissions, regardless of whether they have health plan or health insurance coverage.

II. STATE OF EXISTING LAW

The Knox-Keene Health Care Service Plan Act of 1975 ("Knox-Keene Act"), which governs health plans, seeks to balance the

21. *Id.* at 1–2.

22. *Id.* at 2.

23. Draft Postclaims Underwriting Regulations, CAL. CODE REGS. tit. 28 §§ 1300.89.1, 1300.89.3 (2006), available at <http://www.consumerwatchdog.org/resources/DraftPCUWRRegs.pdf> ("No subscriber contract shall be cancelled or rescinded because of a misstatement or omission in the coverage contract, unless the misstatement or omission is a result of the applicant's willful misrepresentation and the omitted information would have been a basis for denial of coverage pursuant to the plan's underwriting criteria, guidelines, policies, and procedures.").

24. See KELSO, *supra* note 1.

competing interests of health plans and the people they insure, which by their nature are adverse.²⁵ On average, families spend \$13,375²⁶ a year on health coverage policies to ensure that they will have access to health care when it is necessary.²⁷ Health plans seek to limit their exposure to large medical claims by refusing to sell policies to applicants with preexisting health problems or limiting payouts once a policy has been sold.²⁸ In striking a balance between the two sides' competing interests, the California Supreme Court has established that once an insurance company grants a policy for coverage, it must give at least as much consideration to the insured's interests in accessing health care as it does to its own interest in maximizing financial gain.²⁹ This balancing should work to constrain a company from profiting by wrongfully rescinding health coverage.

Unlike the twelve states that bar health plans from refusing to sell health coverage based on an applicant's health history,³⁰ California law allows health plans to refuse to sell a coverage policy to an applicant with even minor health problems.³¹ Thus, health plans

25. See WILLIAM M. SHERNOFF ET. AL., INSURANCE BAD FAITH LITIGATION § 1.02 (Lexis Nexis 2004) ("The tort of bad faith has grown out of an appreciation of the fact that an insurance contract is . . . totally inadequate in protecting the consumer from the wrongful denial of insurance claims."); see also DMHC Amicus, *supra* note 3, at 20 ("[T]he final version of section 1389.3 balanced the competing concerns of protecting California consumers from discriminatory practices by health insurance companies and of allowing health plans to protect against fraud.").

26. KAISER FAMILY FOUND. AND HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS SURVEY, 2009 ANNUAL REPORT 14 (2009), available at <http://ehbs.kff.org/pdf/2009/7936.pdf>.

27. This Note focuses on the California individual health insurance market. Individual policies for individual or family coverage are purchased directly by the consumer, sometimes with the assistance of an insurance broker. The recent policy rescissions in California *have occurred among individually purchased policies* rather than group policies provided by employers. Under California law, health plans may medically underwrite individuals and their families in the individual market and refuse to sell coverage based on an applicant's condition, but they may not do so in the group market. Such rescissions based on an allegation that the patient misrepresented a health condition when applying for coverage do not exist in twelve states that bar insurers from using health histories as a basis for determining eligibility for individual health insurance. See NCSL HEALTH PROGRAM, NAT'L CONFERENCE OF STATE LEGISLATURES, STATE SMALL GROUP HEALTH REFORM—A BRIEF HISTORY 2–3 (2006) [hereinafter NCSL REPORT]; see also discussion *infra* Part III.C (discussing in greater detail the use of rescission as a remedy).

28. See SHERNOFF, *supra* note 25, at § 1.01.

29. Egan v. Mutual of Omaha Ins. Co., 620 P.2d 141, 145 (Cal. 1979).

30. NCSL REPORT, *supra* note 27, at 2–3.

31. CAL. HEALTH & SAFETY CODE § 1389.1 (West 2007); see also Press Release, Consumer Watchdog, Internal Documents Show Insurers Won't Sell Health Policies to Cops, Firefighters, Expectant Dads, Allergy & Acne Sufferers, etc., (Jan. 8, 2007), available at <http://www.consumerwatchdog.org/patients/articles/?storyId=15166> (stating that underwriting guidelines allow

commonly require applicants to detail their medical histories on enrollment applications and to provide access to medical records before a policy is issued.³² Electronic databases make accessing an applicant's medical files by health plans cost-effective and efficient.³³

Once information is collected, the health plan begins the process known as "underwriting" during which the applicant's health history is compared to preestablished guidelines. These underwriting guidelines, developed and controlled by health plans,³⁴ determine whether an applicant who currently has or has had health problems will be sold a policy for coverage.³⁵ So-called preexisting health conditions disclosed on applications commonly lead health plans to refuse to sell policies.³⁶

Congruously, Health and Safety Code section 1389.3 requires health plans to decide whether to provide coverage to a patient by completing the underwriting process *before* the policy is sold.³⁷ This seemingly obvious requirement is a linchpin in balancing the interests of the health plan and the interests of the patient. The health plan retains the ability to limit risk exposure prior to issuing a coverage policy. Meanwhile, if denied a policy up front, the consumer may shop around for coverage elsewhere.

However, once a health plan issues a coverage contract, that contract is a promise that the health plan will protect enrollees against future financial losses resulting from illness and injury in exchange for timely payments of premiums.³⁸ But, health plans routinely violate the underwriting requirements of section 1389.3 by

insurers to deny coverage to patients with minor health conditions, such as asthma, acne, allergies, and toenail fungus).

32. California Dep't of Insurance, Consumers: Individual Health Insurance Underwriting, <http://www.insurance.ca.gov/0100-consumers/0070-health-issues/ind-health-insurance-underwriting-ab-356.cfm> (last visited Feb. 7, 2010).

33. See Brief of United Policyholders as Amicus Curiae Supporting Appellants at 6–9, *Hailey v. Cal. Physicians' Serv.*, 69 Cal. Rptr. 3d 789 (Ct. App. 2007) (No. G035579) (pointing out that medical records may be accessed for \$2.42 per patient); JON SHREVE, MILLMAN INC., *THE IMPACT OF THE MIB CHECKING SERVICE ON HEALTH INSURANCE UNDERWRITING 1* (2007) (stating that the use of medical record databases saves health insurers an average of \$46 for every \$1 spent).

34. CAL. HEALTH & SAFETY CODE § 1389.4.

35. California Dep't of Insurance, *supra* note 32.

36. *Id.*

37. CAL. HEALTH & SAFETY CODE § 1389.3.

38. SHERNOFF, *supra* note 25, at § 1.02.

waiting to investigate a patient's insurance risk until *after* receiving high-dollar-value claims³⁹—a procedure known as “postclaims underwriting”⁴⁰—even though this practice is illegal under California law and invalidates any rescission resulting from such a review.⁴¹

The key distinction, of course, between illegal postclaims underwriting and the allowed precontract investigation into an applicant's insurability is timing. Health plans engaging in postclaims underwriting issue coverage with little or no investigation into an applicant's insurability.⁴² Then, once a high-dollar-value claim is filed, the health plan seeks to avoid contract liability by aggressively investigating a patient's medical records and application, looking for any “minutiae in the insured's medical history to avoid payment on the claim and to justify rescission of the contract.”⁴³

When it comes to health coverage rescissions, hindsight is 20/20. According to health plans, because any omission or misrepresentation on an application provides the basis for rescission, a health plan seeking to rescind the coverage of an ill patient will almost certainly find a reason to do so.⁴⁴ Thus, postclaims underwriting has been called “an underwriting abomination . . . an artificial vehicle for contract avoidance . . . quintessentially opportunistic.”⁴⁵ Further, plaintiffs' attorneys allege that intentionally vague questions on enrollment applications are

39. Girion, *supra* note 10, at A1.

40. Thomas C. Cady & Georgia Lee Gates, *Post Claim Underwriting*, 102 W. VA. L. REV. 809, 810 (2000).

41. CAL. HEALTH & SAFETY CODE § 1389.3.

42. Cady & Gates, *supra* note 40, at 823–24.

43. DMHC Amicus, *supra* note 3, at 10–11.

44. *Ticconi v. Blue Shield of Cal. Life & Health Ins. Co.*, 72 Cal. Rptr. 3d 888, 893 (Ct. App. 2008) (“Blue Shield Life explained that short-term policies are wholly underwritten through the questions on the application.”).

45. Cady & Gates, *supra* note 40, at 810; *see also* Hailey v. Cal. Physicians' Serv., 69 Cal. Rptr. 3d 789, 805–06 (Ct. App. 2007) (“Blue Shield's underwriting investigator testified the company referred approximately 1,000 claims a year to her for investigation of possible misrepresentations or omissions in the subscribers' applications. Yet, she testified she decides to rescind in less than one percent of the cases she investigates. These facts raise the specter that Blue Shield does not immediately rescind health care contracts upon learning of potential grounds for rescission, but waits until the claims submitted under that contract exceed the monthly premiums being collected. In other words, a health care services plan may not adopt a ‘wait and see’ attitude after learning of facts justifying rescission by continuing to collect premiums while keeping open its rescission option if the subscriber later experiences a serious accident or illness that generates large medical expenses.”).

designed to induce applicants to omit or misrepresent their health histories, thereby providing the basis for policy rescissions when patients file claims for an expensive treatment.⁴⁶

Rescission of health coverage following an illness and claims for treatment has a particularly harsh impact on the patient. Rescinded coverage is cancelled as of the day of issuance, leaving patients to pay unpaid medical bills, and possibly even to reimburse health plans for medical bills that health plans have already paid.⁴⁷ Patients left without health coverage may suffer great personal hardship or bankruptcy and must often rely on overstretched public health programs for ongoing medical treatment.⁴⁸ To protect the interests of society, patients and health plans, Health and Safety Code section 1389.3⁴⁹ was intended to prohibit a health plan from rescinding coverage once a contract has been approved and issued, except in instances where a patient is shown to have “willfully misrepresented” health conditions on her application for coverage.⁵⁰ This standard limits the rescission remedy to instances where an applicant committed fraud during the application process by concealing a known health condition.⁵¹ If the patient is innocent of such concealment, the health plan bears the risk of having to provide health coverage in accordance with the coverage contract.⁵² But, health plans routinely violate this requirement by rescinding policies

46. Complaint, *supra* note 12, at 2.

47. *Hailey*, 69 Cal. Rptr. 3d at 799.

48. Himmelstein, *supra* note 8.

49. CAL. HEALTH & SAFETY CODE § 1389.3 (West 2007).

50. See Letter from Art Torres, Chair, Senate Comm. on Ins., Claims and Corps., to Governor Peter Wilson (Sept. 24, 1993) (on file with author). In enacting AB 1100, the legislative vehicle for Health and Safety Code section 1389.3, the legislature barred postclaims underwriting, defined as “[t]he practice by an insurer, following a claim by an insured, of unilaterally rescinding a contract based on alleged—often minor—misrepresentations on the application or enrollment form. This bill would prohibit insurers from going back and canceling coverage. . . . Fraud is not protected! Nothing in this bill limits the ability of an insurance company to deny benefits when the applicant has made fraudulent statements in their application.” *Id.*; accord DMHC Amicus, *supra* note 3, at 17 (“In enacting section 1389.3, the Legislature sought to prevent the grievous harm caused by the pernicious practice of post-claims underwriting to AIDS victims and those with other chronic illnesses. . . . [To accomplish these goals,] the Legislature expressly prohibited postclaims underwriting and required health plans to meet the burden of demonstrating that an enrollee willfully misrepresented his or her health history before taking the harsh remedy of rescission, as evidenced by the chosen language.” (emphasis added)).

51. DMHC Amicus, *supra* note 3, at 17.

52. See *id.*

because of omissions on enrollment applications regardless of whether those omissions were “willful.”⁵³

Health and Safety Code section 1389.3’s requirement for a showing of willful misrepresentation before health coverage may be rescinded is consistent with the fairness doctrine applicable to health insurers established by the California Supreme Court.⁵⁴ Those principles, as well as the legislative intent of section 1389.3, are at odds with the DMHC regulators’ view that a patient’s state of mind at the time she completed her application for coverage is not an essential factor in determining whether a rescission is rightful.⁵⁵ In *Thompson v. Occidental Life Insurance Co.*,⁵⁶ the California Supreme Court found that a failure to disclose medical information could not provide the basis for voiding coverage if the applicant “had no present knowledge of the facts sought, or failed to appreciate the significance of information related to him.”⁵⁷ Furthermore, in *Runyan v. Pacifica Air Industries, Inc.*⁵⁸ the supreme court announced that a rescinded party innocent of fraud must be returned to the status quo ante.⁵⁹ However, in the health plan context, it may not be possible to return a patient to the status quo ante, thus rescission may not be a valid remedy for a health plan if the patient is found to be innocent of fraud.⁶⁰

A. Health and Safety Code Section 1389.3

Health and Safety Code section 1389.3 bars “postclaims underwriting,”⁶¹ defined as the rescinding of a policy due to a company’s failure to complete medical underwriting prior to granting coverage.

No health care service plan shall engage in the practice of postclaims underwriting. For purposes of this section, “postclaims underwriting” means the rescinding, canceling,

53. Shernoff Motion, *supra* note 11, at Exhibit A, B & C; DMHC AUDIT, *supra* note 3, at 2.

54. CAL. HEALTH & SAFETY CODE § 1389.3.

55. *Hearing*, *supra* note 2, at 3.

56. 513 P.2d 353 (Cal. 1973).

57. *Id.* at 360.

58. 466 P.2d 682 (Cal. 1970).

59. *Id.* at 691; *see also* discussion *infra* Part III.C (detailing limitations to the rescission remedy in the health plan context).

60. *Runyan*, 466 P.2d at 681.

61. CAL. HEALTH & SAFETY CODE § 1389.3 (West 2007).

or limiting of a plan contract due to the plan's failure to complete medical underwriting and resolve all reasonable questions arising from the 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.*⁶²

The limited right to rescind provided in section 1389.3⁶³ upon a showing of "willful misrepresentation" follows the narrow provisions for canceling or not renewing a health coverage contract, which requires a demonstration of the enrollee's intentional bad faith.⁶⁴ Specifically, Health and Safety Code section 1365 allows health plans to cancel coverage due to an enrollee's "failure to pay" or "fraud or deception."⁶⁵ Under section 1357.54, a health plan may only refuse to renew coverage under an equally narrow set of circumstances, including when an enrollee commits fraud or is found to have made an "intentional misrepresentation of material fact."⁶⁶

In response to widespread reports of policy rescissions,⁶⁷ the DMHC issued draft regulations in October 2007 intended to clarify the requirements of rescission as it relates to health plans.⁶⁸ The regulations interpreted Health and Safety Code section 1389.3 *as barring any health plan rescission unless a patient "willfully misrepresented" a material health condition.*⁶⁹ Thus, the draft regulations are consistent with the legislative intent of section 1389.3 which bars rescission except in limited instances where a patient is shown to have willfully misrepresented a health condition when applying for coverage.

62. *Id.* (emphasis added).

63. *Id.*

64. *See id.* § 1365.

65. *Id.*

66. *Id.* § 1357.54.

67. Girion, *supra* note 3, at C1.

68. Lisa Girion, *Regulators Aim to Curb Healthcare Rescissions*, L.A. TIMES, Oct. 24, 2007, at C1.

69. Draft Postclaims Underwriting Regulations, 28 CAL. CODE REGS. tit. 28 §§ 1300.89.1, 1300.89.3 (2006), available at <http://www.consumerwatchdog.org/resources/DraftPCUWRegs.pdf> ("No subscriber contract shall be cancelled or rescinded because of a misstatement or omission in the coverage contract, unless the misstatement or omission is a result of the applicant's willful misrepresentation and the omitted information would have been a basis for denial of coverage pursuant to the plan's underwriting criteria, guidelines, policies, and procedures.").

B. Hailey v. California Physicians' Service

In December 2007, the California Court of Appeal announced its decision in *Hailey v. California Physicians' Service*,⁷⁰ the only published decision directly interpreting Health and Safety Code section 1389.3.⁷¹

When Cindy Hailey started a new job in late 2000, she opted for an individual policy for her family offered by Blue Shield of California⁷² instead of coverage offered by her employer.⁷³ Cindy claimed that when filling out the application for coverage, she mistakenly believed the application only sought information relating to her health and not that of her husband, Steve. Though Cindy provided information about her own health, she omitted Steve's information.⁷⁴ Based solely on the information provided in the application, Blue Shield granted coverage to the Haileys.⁷⁵

When Steve was admitted to the hospital for stomach problems shortly after coverage was granted, Blue Shield began to investigate the Haileys for possible fraud during the application process.⁷⁶ In the course of the probe, Blue Shield obtained Steve's medical records for the first time,⁷⁷ and based solely on those records, determined that the Haileys had intentionally misrepresented⁷⁸ information about Steve's weight and past medical problems.⁷⁹

Following a car accident that permanently disabled Steve several months later, Blue Shield rescinded the Haileys' health coverage contract.⁸⁰ In addition to refusing to pay \$457,000 in medical bills related to Steve's car accident, Blue Shield demanded that the Haileys pay \$60,777.10—the difference between the amount Blue

70. 69 Cal. Rptr. 3d 789 (Ct. App. 2007).

71. CAL. HEALTH & SAFETY CODE § 1389.3.

72. *Hailey*, 69 Cal. Rptr. 3d at 795–96.

73. *Id.*

74. *Id.* at 796.

75. *Id.*

76. *Id.*

77. *Id.*

78. "Intentional misrepresentation" is the rescission standard referenced in the Blue Cross coverage policies. Blue Cross of California Application (on file with author).

79. *Hailey*, 69 Cal. Rptr. 3d at 796.

80. *Id.*

Shield had paid for Steve's care and the total amount in premiums the Haileys had paid for their health coverage.⁸¹

The Court of Appeal found that Cindy's explanation of her omission of Steve's medical information was supported by the misleading nature of the questions in the application.⁸² The court explained that Cindy's belief that the application was requesting only her information "negates an inference that [Cindy's] understatement of Steve's weight on the application was willful."⁸³ Steve's reliance on Cindy to accurately complete the application "also negates an inference of willfulness."⁸⁴

In its opinion, the *Hailey* court focused on Blue Shield's decision to issue coverage solely on the basis of the information provided in the Haileys' application for coverage.⁸⁵ The court concluded that under Health and Safety Code section 1389.3,⁸⁶ prior to issuing a policy, health plans must complete medical underwriting which requires "a [health] plan to make reasonable efforts to ensure a potential subscriber's application is accurate and complete."⁸⁷

In other words, basing a decision to issue health coverage solely on the information provided on the application, as Blue Shield did in *Hailey*,⁸⁸ does not constitute medical underwriting.⁸⁹ *Hailey* held that where a health plan fails to complete *any* underwriting because it only reviewed the application for coverage, the health plan must show the applicant "willfully misrepresented" the health information in question before rescinding the coverage.⁹⁰

81. *Id.*

82. *Id.* at 798–99.

83. *Id.* at 799. At trial, following remand, the judge issued a directed verdict in which the Haileys stipulated to misrepresenting information on their application for coverage apparently in exchange for Blue Shield dropping a countersuit against them and waiving all court costs and fees. Evan George, *Health Care Ruling Raises Questions for Other Cases*, L.A. DAILY JOURNAL, June 3, 2009, available at <http://www.consumerwatchdog.org/patients/articles/?storyId=27737>.

84. *Hailey*, 69 Cal. Rptr. 3d at 799.

85. *Id.* at 799–800.

86. CAL. HEALTH & SAFETY CODE § 1389.3 (West 2007).

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

88. *Id.* at 796; see also *Ticconi v. Blue Shield of Cal. Life & Health Ins. Co.*, 72 Cal. Rptr. 3d 888, 893 (Ct. App. 2008) ("Blue Shield Life explained that short-term policies are wholly underwritten through the questions on the application.").

89. *Hailey*, 69 Cal. Rptr. 3d at 796.

90. *Id.* at 804. ("Because Blue Shield failed to demonstrate it made reasonable efforts to ensure the Haileys' application was accurate and complete as part of its precontract underwriting

Regulators have taken an astoundingly broad view of *Hailey*. Regulators at the DMHC often cite⁹¹ a broad statement by the *Hailey* court that

section 1389.3 precludes a health services plan from rescinding a contract for a material misrepresentation or omission unless the plan can demonstrate (1) the misrepresentation or omission was willful, *or* (2) it had made reasonable efforts to ensure the subscriber's application was accurate and complete as part of the precontract underwriting process.⁹²

Under the DMHC regulators' reading of *Hailey*, the health plan may rescind as long as the health plan's precontract medical underwriting is deemed to have been a "reasonable effort" to determine whether the application was complete, regardless of whether the omission or misrepresentation was the product of a willful act.⁹³ *Hailey* does not define what constitutes a "reasonable effort" but only provides that relying on the application alone does not constitute medical underwriting.⁹⁴

C. Assembly Bill 1945

Shortly following the ruling in *Hailey*, the California Legislature passed Assembly Bill 1945 ("AB 1945"),⁹⁵ to bring the DMHC regulators' reading of *Hailey*⁹⁶ in line with the legal requirements for rescission by health insurers under California Supreme Court precedent.⁹⁷ The bill stated that a health plan must, prior to rescinding a coverage contract, "demonstrate[] that the applicant intentionally misrepresented or intentionally omitted material information on the application . . . with the purpose of

process, and the Haileys raised a triable issue of fact whether they willfully misrepresented Steve's physical condition when they applied for coverage, we reverse the judgment.").

91. *Hearing, supra* note 2, at 3.

92. *Hailey*, 69 Cal. Rptr. 3d at 795 (emphasis added).

93. *Hearing, supra* note 2, at 3.

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

95. Assemb. B. 1945, 2008 Leg., 2007–2008 Sess. (Cal. 2008).

96. *Hearing, supra* note 2, at 3.

97. *Thompson v. Occidental Life Ins. Co.*, 513 P.2d 353, 360 (Cal. 1973); *Runyan v. Pacifica Air Indus., Inc.*, 466 P.2d 682, 691 (Cal. 1970).

misrepresenting his or her health history in order to obtain health care coverage.”⁹⁸

The need for such legislative clarification is palpable. Industry representatives would gladly ignore the patient-friendly fairness doctrine of *Thompson* and *Runyan*. For instance, when Governor Schwarzenegger vetoed AB 1945, Christopher Ohman—president of the California Association of Health Plans, a lobbying association representing health plans⁹⁹—remarked, “This bill would have undermined 100 years of contract law that allows contracts to be rescinded for failure to disclose a material fact *regardless of intent*.”¹⁰⁰

III. CRITIQUE

The DMHC regulators’ reading of *Hailey*¹⁰¹ contradicts existing law and doctrine in several ways. First, the regulators’ reading of *Hailey*¹⁰² contravenes public policy articulated by the regulators themselves¹⁰³ as well as the legislative intent of the Health and Safety Code. Second, it violates long-standing principles of *stare decisis* that restrict legal precedent established by court rulings to the facts and issues of the cases decided.¹⁰⁴ Third, it is inconsistent with the California Supreme Court fairness doctrine that applies to health insurers,¹⁰⁵ part of which was interpreted by *Hailey* to apply to health plans.¹⁰⁶

98. Cal. Assemb. B. 1945. The California Health and Safety Code section 1389.3 requirement for a showing of “willful misrepresentation” was changed to “intentional misrepresentation” in response to health plan complaints that the term *willful* was not well defined in legal literature. *Willful* and *intentional* misrepresentations are considered functionally equivalent legal standards by the DMHC for the purposes of health plan rescission. See DMHC Amicus, *supra* note 3, at 22 n.31. *Intentional* is defined as “done with the aim of carrying out the act.” BLACK’S LAW DICTIONARY 826 (8th ed. 2004). *Willful* is defined as “[v]oluntary and intentional, but not necessarily malicious.” *Id.* at 1630.

99. California Ass’n of Health Plans, About Us, <http://www.calhealthplans.org/about/index.cfm> (last visited Feb. 7, 2010).

100. John Howard & Anthony York, *Schwarzenegger Vetoes Rescission Bill*, CAPITOL WEEKLY, Sept. 30, 2008, at A1 (emphasis added).

101. *Hearing, supra* note 2, at 3.

102. *Hearing, supra* note 2, at 3.

103. See DMHC Amicus, *supra* note 3, at 32.

104. *Hart v. Burnett*, 15 Cal. 530, 598–99 (1860).

105. *Thompson v. Occidental Life Ins. Co.*, 513 P.2d 353, 360 (Cal. 1973); *Runyan v. Pacifica Air Indus., Inc.*, 466 P.2d 682, 691 (Cal. 1970).

106. *Hailey*, 69 Cal. Rptr. 3d. at 802.

It is clear that the regulators' broad reading of *Hailey*¹⁰⁷ provides incentives to health plans that are contrary to sound public policy and statutory requirements.¹⁰⁸ Under the DMHC regulators' interpretation, health plans now have a financial interest in doing just enough precontract underwriting to retain their right to rescind coverage when patients file claims for high-dollar health care treatment.¹⁰⁹ Perversely, the regulators' reading of *Hailey* encourages health plans to conduct minimal precontract investigations, issue coverage, collect premiums,¹¹⁰ and then retroactively cancel the coverage of those enrollees who become seriously ill.¹¹¹

Imagine the following scenario: Months before an applicant fills out an application for health coverage, her doctor informs her that she has a heart murmur. The doctor explains that the heart murmur is a common condition, which does not require medical treatment and would not negatively affect her health. When the applicant later fills out her application for coverage, in response to a question asking her whether she has any "health problems," she answers "no." After all, her physician has told her that the heart murmur does not require any treatment. How could it then be a "health problem"? The applicant has no intent to misrepresent her health condition. Once the

107. *Hearing, supra* note 2, at 3.

108. *See* DMHC Amicus, *supra* note 3, at 31–32.

109. *See* Complaint, *supra* note 12, at 2; *see also* Girion, *supra* note 10, at A1 (reporting that Blue Cross reviews medical records and investigates a patient's insurance risk after receiving high-dollar-value insurance claims).

110. *See* *Hailey v. Cal. Physicians' Serv.*, 69 Cal. Rptr. 3d 789, 796 (Ct. App. 2007); FINANCIAL REPORTING, DEP'T OF MANAGED HEALTH CARE, ANNUAL FINANCIAL REPORTING FORM 3 (2008), available at <http://wps.dmhc.ca.gov/fe/search/#top>. Though health plans often return premiums to policyholders after rescinding policies, health plans retain investment income earned off those premiums. By retaining investment income, as well as preventing payouts for medical coverage for ill or injured policyholders, insurers profit from illegal rescissions.

111. Since the rescission surge beginning in 2001, HMOs have experienced an explosion in profitability. Between 2001 and 2005, HMOs nationally increased their first-quarter profits by 990 percent. Consumer Watchdog, Fact Sheet—Health Plan Profitability (2008), <http://www.ConsumerWatchdog.org/resources/HealthPlanProfits.pdf>. In total, just four California health plans transferred at least \$4 billion in profit to out-of-state parent companies since 2002. *Id.* Health plans have also amassed reserves far in excess of state-required levels. *Id.* Just three companies, including Blue Cross and the non-profits Kaiser Permanente and Blue Shield of California, reported \$16.4 billion in excess reserves. *Id.*; *see also* Lisa Girion, *Health Insurer Tied Bonuses to Dropping Sick Policyholders*, L.A. TIMES, Nov. 9, 2007, at D1. According to court documents, California-based Health Net Inc. avoided paying \$35.5 million in medical expenses by illegally rescinding approximately 1,600 policies between 2000 and 2006. Girion, *supra*. Instead of paying medical claims, Health Net paid bonuses to personnel overseeing rescissions—the higher the dollar-value savings for the company, the higher the bonuses paid to staff carrying out those rescissions. *Id.*

application is completed, the health plan conducts an investigation to determine the applicant's insurability but misses the physician's note in the medical file regarding the patient's heart murmur.

After the coverage is issued, the patient is diagnosed with cancer, and the health plan authorizes a doctor to conduct emergency surgery. When a bill for \$200,000 for the surgery and hospital stay is submitted to the health plan for payment, the health plan then conducts another review of the patient's records, and this time finds the doctor's note about the patient's heart murmur.¹¹²

The health plan argues, in accordance with the DMHC's interpretation of *Hailey*, that since it completed some precontract investigation, the review following the filing of the claim does not constitute illegal postclaims underwriting.¹¹³ The health plan's postclaim action is valid, according to the DMHC, as long as the health plan completed a "reasonable" review prior to issuing the coverage.¹¹⁴

The health plan then rescinds coverage from the day it was issued, stating that if it had known about the patient's heart murmur, the health plan would have never issued the coverage in the first place.¹¹⁵ The patient must then pay the cost of the cancer treatment herself or, as is more likely, declare bankruptcy and possibly not receive further treatment.¹¹⁶

In addition to the clear contradictions with supreme court precedent outlined below, the DMHC's interpretation of *Hailey* contravenes overarching legislative principles of the Knox-Keene Act, which provides for the regulation of health plans.¹¹⁷ For example, Health and Safety Code section 1342 states that its legislative intent is to "promote the delivery and the quality of health and medical care" by "[h]elping to ensure the best possible health care for the public at the lowest possible cost by transferring the financial risk of health care from patients to providers."¹¹⁸

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

113. See Brief of Respondent-Appellee at 2, *Hailey v. Cal. Physicians' Serv.*, 69 Cal. Rptr. 3d 789 (Ct. App. 2007).

114. *Id.*

115. *Id.*

116. See Himmelstein, *supra* note 8.

117. See *supra* note 1 and accompanying text.

118. CAL. HEALTH & SAFETY CODE § 1342 (West 2007).

Prior to the *Hailey* decision, the DMHC agreed that “[t]he Legislature gave paramount importance to protecting the rights of enrollees to the benefit of their bargain [by requiring health] plans [to] assume financial risk, and allowed [health] plans alternative ways to safeguard their legitimate interests.”¹¹⁹

However, by allowing a health plan to rescind coverage as long as the health plan completes “reasonable” precontract underwriting, the DMHC effectively shifts the financial risk of health care from the health plan to the patient. Under the regulators’ interpretation of *Hailey*,¹²⁰ the patient bears the risk of a health plan’s failure to discover objectionable health information during the health plan’s precontract investigation. Furthermore, such an outcome is problematic based on the very same public policy objections leveled against postclaims underwriting, “an artificial vehicle for contract avoidance . . . quintessentially opportunistic.”¹²¹

A. Appellate Review

DMHC officials often cite the *Hailey* decision as the reason for the shift in their interpretation of Health and Safety Code section 1389.3 to one not requiring a showing of “willful misrepresentation” in cases where minimal precontract underwriting was completed.¹²² However, the regulators’ new position relies on an overly broad interpretation of *Hailey*. That reliance conflicts with long-established principles of judicial interpretation.

Under California law, a decision is considered binding authority only on subsequent cases that match the specific facts and legal issues considered by the court.¹²³ Despite the broad language of a

119. DMHC Amicus, *supra* note 3, at 26.

120. *Hearing*, *supra* note 2, at 3.

121. Cady & Gates, *supra* note 40, at 810; *see also* *Hailey v. Cal. Physicians’ Serv.*, 69 Cal Rptr. 3d 789, 805–06 (Ct. App. 2007) (“[A] health care services plan may not adopt a ‘wait and see’ attitude after learning of facts justifying rescission by continuing to collect premiums while keeping open its rescission option if the subscriber later experiences a serious accident or illness that generates large medical expenses.”).

122. *See, e.g.*, Evan George, *State Will Reinstate Cancelled Health Policies*, L.A. DAILY J., April 18, 2008, at A1; *see also* CAL. S. JUDICIARY COMM., COMMITTEE REPORT FOR AB 1945, 2007–2008 Sess., at 8 (2008) (“The *Hailey* decision . . . seemingly allows a health plan to rescind on a standard less than willful misrepresentation . . .”).

123. *Hart v. Burnett*, 15 Cal. 530, 598–99 (1860) (“A decision is not even authority except upon the point actually passed upon by the Court and directly involved in the case. But even then, the mere reasoning of the Court is not authority. The point decided by the Court, and which the reasoning illustrates and explains, constitutes a judicial precedent. The books are full of cases in

judgment, the *ratio decidendi*, or the part of a holding having the effect of precedent, is confined to the facts and issues before the court.¹²⁴ To discern precedent from dicta,

[i]t is therefore necessary to read the language of an opinion in the light of its facts and the issues raised, to determine (a) which statements of law were *necessary to the decision*, and therefore binding precedents, and (b) which were arguments and general observations, unnecessary to the decision, i.e., dicta, with no force as precedents.¹²⁵

As discussed above, *Hailey* provides in part that a health plan may rescind a contract for a material misrepresentation or omission if the health plan can “demonstrate (1) the misrepresentation or omission was willful, or (2) [the health plan] made reasonable efforts to ensure the insured’s application was accurate and complete” before issuing coverage.¹²⁶

Under *Hart v. Burnett*¹²⁷ and the doctrine of *ratio decidendi*, the precedential value of *Hailey* is limited to the facts and legal issues raised by the case and the statements of law necessary to the decision.¹²⁸ Therefore, *Hailey* is binding authority only in circumstances where a health plan does not make *any* attempt to confirm that the application for coverage is accurate and complete before issuing coverage.¹²⁹ In those instances, under the *ratio decidendi* of *Hailey*, a health plan must establish that the insured willfully misrepresented a health fact on the application as a condition of rescinding a coverage contract.¹³⁰ This is the extent of the binding authority of *Hailey*.

The broad language in *Hailey* that suggests a health plan does not have to establish a patient’s willful misrepresentation in

which learned Judges have earnestly deprecated the attempt to urge the mere *dicta*, or the arguments of Judges, as authoritative expositions of the law.”); *see also* *Achen v. Pepsi-Cola Bottling Co.*, 233 P.2d 74, 81 (Cal. Ct. App. 1951) (explaining that an appellant citing argumentative language from a prior case did not provide the court with binding authority because such arguments were not part of the prior case’s holding).

124. 9 B.E. WITKIN, CALIFORNIA PROCEDURE § 509 (5th ed. 2008).

125. *Id.* (emphasis added).

126. *Hailey*, 69 Cal. Rptr. 3d at 795.

127. 15 Cal. 530, 598–99 (1860).

128. *See* WITKIN, *supra* note 124.

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

130. *See id.* at 804.

circumstances where the health plan completes “reasonable” precontract underwriting¹³¹ is not binding authority—it is just dicta. The *Hailey* decision rests on section 1389.3’s bar on postclaims underwriting, which prohibits policy rescissions “due to the plan’s failure to complete medical underwriting.”¹³² According to the facts of *Hailey*, Blue Shield did not complete *any* underwriting.¹³³ Therefore, it was *not necessary* for the *Hailey* court to decide whether Blue Shield, or any health plan, must establish that an applicant willfully misrepresented¹³⁴ a health fact on an application for coverage to determine the legality of rescission in instances where a health plan completed “reasonable” medical underwriting.

In other words, the central legal precedent of *Hailey* is the requirement that health plans complete medical underwriting prior to issuing a contract for coverage, not which legal standard applies when underwriting is completed.¹³⁵ Thus, the DMHC regulators incorrectly relied on the *Hailey* court’s statement that it is unnecessary for a health plan to meet the willful misrepresentation requirement in instances where precontract underwriting was ‘reasonable.’ That statement is unnecessary to the decision (i.e., dictum), and does not have the effect of precedent.¹³⁶

B. Role of Knowledge and Understanding in Supreme Court Precedent

Not only is the DMHC regulators’ interpretation of *Hailey* inconsistent with principles of judicial interpretation, it also conflicts with the public policy goals of the fairness doctrine articulated in California Supreme Court precedents. In particular, the California Supreme Court has provided protections against coverage rescission for innocent health insurance patients¹³⁷ relying on California

131. *Id.* at 795.

132. *Id.* at 798; *see also* CAL. HEALTH & SAFETY CODE § 1389.3 (West 2007) (“No health care service plan shall engage in the practice of postclaims underwriting.”).

133. *Hailey*, 69 Cal. Rptr. 3d at 796 (“Based on the information provided in the application, Blue Shield extended coverage to Cindy and her family at its ‘premier’ or best rate . . .”).

134. *Id.*

135. *See id.* at 804.

136. *See* WITKIN, *supra* note 124; *see also* Hart v. Burnett, 15 Cal. 530, 598–99 (1860) (explaining that “general expressions” within a particular case help illustrate questions before the court but do not control judgments beyond the case because such expressions do not receive the same amount of investigation as the primary issues).

137. *Thompson v. Occidental Life Ins. Co.*, 513 P.2d 353, 360 (Cal. 1973).

Insurance Code statutes applying to health insurers, not Health and Safety Code statutes applying to health plans. The general principle is that if an applicant for coverage was unaware of a health condition, or did not understand the nature of the condition, the failure to disclose that health information on an application for coverage is insufficient grounds for rescinding a coverage contract.¹³⁸ This protection persists regardless of whether a health insurer completes “reasonable” precontract underwriting.¹³⁹ Simply, supreme court precedent is at odds with the DMHC regulators’ overbroad reading of *Hailey*,¹⁴⁰ holding that a health insurer may not rescind an insurance contract based on an alleged misrepresentation if the applicant did not have the requisite state of mind.¹⁴¹

In *Thompson v. Occidental Life Insurance Co.*, the California Supreme Court found that a failure to disclose medical information could not provide the basis for rescission if the applicant “had no present knowledge of the facts sought, or failed to appreciate the significance of information related to him.”¹⁴² Further, a health insurer bears the burden of proving that a misrepresentation occurred.¹⁴³ The misrepresentation is established by negating to the satisfaction of the trier of fact various plausible explanations by the applicant for the incomplete answers on an application.¹⁴⁴

In *Thompson*, the plaintiff challenged a life insurance company’s refusal to honor a policy on the basis of fraud. The insurer, Occidental, alleged that the deceased, Donald Thompson, had misrepresented approximately ten medical consultations he had with five different doctors.¹⁴⁵ Occidental alleged that Thompson also failed to disclose several minor health conditions and one major problem, arteriosclerosis, or hardening of the arteries.¹⁴⁶ The latter, Occidental claimed, had substantially reduced Thompson’s life

138. *See id.*

139. *Thompson* considers a life insurance contract governed by the Insurance Code, which applies to health insurance companies but does not apply to health care service plans governed by the Health and Safety Code.

140. *Hearing*, *supra* note 2, at 3.

141. *Thompson*, 513 P.2d at 360.

142. *Id.*; *Ransom v. Penn Mut. Life Ins. Co.*, 274 P.2d 633, 636 (Cal. 1954).

143. *Thompson*, 513 P.2d at 362.

144. *Id.* at 363.

145. *Id.* at 360.

146. *Id.* at 361.

expectancy,¹⁴⁷ and Thompson's failure to disclose the condition constituted a fraudulent misrepresentation of his health condition.¹⁴⁸

Under *Thompson*, however, the insured's state of mind at the time of applying for coverage is essential to determining whether the applicant had the capacity to "misrepresent" the information in question.¹⁴⁹ In fact, the term "misrepresentation" denotes a positive act of deception or concealment. "Misrepresentation" is commonly defined as "making a false or misleading assertion about something, usually with the intent to deceive."¹⁵⁰ Conversely, an "innocent misrepresentation" is a "false statement that the speaker or writer *does not know* is false."¹⁵¹ The supreme court blocked Occidental's attempt to hold the insurance policy void on the basis of fraud, finding that Thompson lacked the state of mind to misrepresent his health condition.¹⁵² A successful action to "void" a contract is similar in outcome to an action to rescind because a voided contract is considered to have "no legal effect,"¹⁵³ whereas a rescinded contract is a considered retroactively revoked.¹⁵⁴

The *Thompson* court noted that in regards to the arteriosclerosis, none of Thompson's doctors had informed him that he had the disease.¹⁵⁵ Further, the court concluded that Thompson plausibly did not disclose the leg pain associated with the arteriosclerosis because he believed it to be related to a varicose vein condition that he had disclosed.¹⁵⁶ Regarding the various undisclosed physician consultations, the *Thompson* court found that the medical terms used by physicians during those visits "might well have been meaningless jargon to him."¹⁵⁷ Thus, the trial court might have conceivably

147. *Id.*

148. *See id.*

149. *See id.* at 360.

150. BLACK'S LAW DICTIONARY 1022 (8th ed. 2004).

151. *Id.* (emphasis added).

152. *See Thompson*, 513 P.2d at 361.

153. BLACK'S, *supra* note 150, at 1604.

154. *Id.* at 1332.

155. *Thompson*, 513 P.2d at 361.

156. *Id.* Thompson's doctor had told him that the leg pain he was experiencing had "something to do with circulation." According to Dr. Pellegrin, "You don't want to get somebody all wound up and alarmed and concerned [by telling them they have a serious illness]." *Id.*

157. *Id.* at 362.

believed that Thompson, a layman, “failed to recollect or appreciate the significance of the various consultations.”¹⁵⁸

In the words of the *Hailey* court, Thompson’s failure to comprehend the significance of his health condition negated his ability to misrepresent it.¹⁵⁹ Further, Occidental failed in its duty to rule out “plausible explanations for the incomplete answers on Thompson’s application.”¹⁶⁰ Such explanations may reasonably explain why Thompson failed to disclose the medical information.¹⁶¹ Therefore, Occidental could not hold the contract void on the basis of misrepresentation.¹⁶²

The *Thompson* court’s refusal to allow an insurer to void a contract for coverage in circumstances where the patient did not know of, or did not understand the importance of, the medical information that the insurer claims was misrepresented¹⁶³ contradicts the DMHC regulators’ overbroad reading of *Hailey*. The latter’s straitjacket approach, in instances where the health plan completed “reasonable” precontract underwriting, is unconcerned with the applicant’s awareness of, or understanding of, the health information omitted or misrepresented on the application for coverage.¹⁶⁴

Other supreme court precedents applying to health insurers also contradict the DMHC regulators’ position on the current law governing health plan rescissions in instances where the applicant layman did not understand the medical information related to him by his doctor. In *Cohen v. Penn Mutual Life Insurance Co.*,¹⁶⁵ the court found that a layman’s failure to understand the meaning of certain medical terms might provide a reasonable explanation for an

158. *Id.*

159. *See supra* note 83 and accompanying text; *see also Thompson*, 513 P.2d at 360 (“Questions concerning illness or disease do not relate to minor indispositions but are to be construed as referring to serious ailments . . .”); *Cohen v. Penn Mut. Life Ins. Co.*, 312 P.2d 241, 244 (Cal. 1957) (“[A] layman might reasonably be excused if, in disclosing information, he failed to understand the meaning of certain medical terms and for that reason omitted some fact in his medical history.”).

160. *Thompson*, 513 P.2d at 363.

161. *Id.*

162. *Id.*

163. *Id.* at 360.

164. *Hearing, supra* note 2, at 3.

165. 312 P.2d 241 (Cal. 1957).

applicant's failure to disclose a medical condition.¹⁶⁶ In *Cohen*, the insured was in fact deemed to have known that he suffered from high blood pressure.¹⁶⁷ The insured, Cohen, a physician himself, acknowledged certain ailments under oath as a condition of receiving an army commission prior to applying for insurance coverage.¹⁶⁸ For that reason, the court found adequate grounds for the trial court's finding that Cohen had the state of mind necessary to misrepresent his health information on the application for coverage.¹⁶⁹

On the other hand, in *Ransom v. Penn Mutual Life Insurance Co.*, which preceded *Cohen*, the supreme court found that the insured did not misrepresent that he had high blood pressure, and that an action to void the policy on the basis of fraud was invalid.¹⁷⁰ In *Ransom*, a doctor had informed the insured that he had "mild hypertension," but the court concluded that it was unclear whether the insured knew what the term meant, and that the insured thus conceivably lacked the state of mind to misrepresent the condition on his application for coverage.¹⁷¹ The holdings of *Cohen* and *Ransom* conflict with the DMHC regulators' reading of *Hailey* because under the latter's approach, the layman's lack of knowledge is not an essential factor in determining whether a rescission is an appropriate remedy in the health plan context.¹⁷²

The hypothetical discussed above¹⁷³ provides a possible scenario under the DMHC's interpretation of the law following *Hailey*,¹⁷⁴ but is inconsistent with the principles announced by the California Supreme Court in *Thompson*¹⁷⁵ and *Cohen*.¹⁷⁶ In the hypothetical, doctors told the patient that the heart murmur condition did not require treatment. Such advice from a physician could certainly

166. *Id.* at 244; *see also* *Ransom v. Penn. Mut. Life Ins., Co.*, 274 P.2d 633, 637 (Cal. 1954) (finding that a patient who did not understand the meaning of "hypertension" might have reasonably failed to understand that the term related to blood pressure).

167. *Cohen v. Penn Mut. Life Ins. Co.*, 312 P.2d 241, 243 (Cal. 1957).

168. *Id.*

169. *See id.* at 244.

170. *Ransom*, 274 P.2d at 636.

171. *Id.* at 637.

172. *Hearing*, *supra* note 2, at 3.

173. *See* discussion *supra* Part III.

174. *Hearing*, *supra* note 2, at 3.

175. *Thompson v. Occidental Life Ins. Co.*, 513 P.2d 353, 360 (Cal. 1973).

176. *Cohen v. Penn Mut. Life Ins. Co.*, 312 P.2d 241, 244 (Cal. 1957).

provide a jury with a plausible explanation under the *Thompson* doctrine¹⁷⁷ for the applicant's failure to disclose this condition when asked about "health problems" on the application for coverage.

Such a statement about the nature of the condition from a physician negates an applicant's capacity for misrepresentation.¹⁷⁸ A health plan's failure to rule out the possibility that the reason for the nondisclosure was the applicant's misunderstanding that the heart murmur was a health condition requiring disclosure would also bar a lower court from finding that the condition was misrepresented under the *Thompson* doctrine.¹⁷⁹

A similar outcome is reached under the principles applied by the *Ransom* court in deciding that a layman's failure to understand complex medical terms negated his capacity for misrepresentation. An explanation by a physician that suggests the patient's condition is not "medical" in nature because it warrants no treatment, as in our hypothetical, provides a reasonable basis for the applicant's failure to report it in response to an application question inquiring about "medical conditions."¹⁸⁰ Under the *Thompson* analysis,¹⁸¹ when the applicant has been told about a condition, but due to the nature of the disclosure, the patient does not "appreciate the significance of the subject matter" related to him,¹⁸² "incorrect or incomplete responses [on an application for coverage do] not constitute grounds for rescission."¹⁸³

The application of the *Thompson* doctrine¹⁸⁴ to the *Hailey* scenario would provide a similar result.¹⁸⁵ Where the *Hailey* court found that Cindy Hailey's misunderstanding of the application question negates an inference of willful misrepresentation,¹⁸⁶ a court deciding the same issue under the *Thompson* doctrine would likely find that an applicant's failure to understand whose health

177. *Thompson*, 513 P.2d at 360.

178. See *supra* note 83 and accompanying text; see also *Thompson*, 513 P.2d at 360; *Cohen*, 312 P.2d at 244.

179. See *Thompson*, 513 P.2d at 360.

180. *Cohen*, 312 P.2d at 244.

181. *Thompson*, 513 P.2d at 360.

182. *Id.* at 362.

183. *Id.* at 360.

184. *Id.* at 360.

185. *Hailey v. Cal. Physicians' Serv.*, 69 Cal. Rptr. 3d 789, 800 (Ct. App. 2007).

186. *Id.* at 799.

information is sought on an application means that the applicant has “no present knowledge of the facts sought.”¹⁸⁷ The key distinction, however, is that the *Thompson* rule applies regardless of the level of precontract medical underwriting that is completed.

C. Status Quo Ante: Limits on the Rescission Remedy

The DMHC regulators’ overbroad reading of *Hailey*¹⁸⁸ is also in conflict with statutory and common law restrictions on the application of the rescission remedy.¹⁸⁹ Namely, the regulators’ interpretation is directly at odds with the requirement that both parties be returned to the status quo ante following a rescission.¹⁹⁰

In the context of health plan rescissions, it is often impossible to return a patient whose policy was rescinded to the status quo ante—a position in which the patient could purchase new individual health coverage from another health plan.¹⁹¹ Since a health coverage rescission often occurs following a major illness, rescinded patients will find it difficult, and likely impossible, to obtain new coverage since health plans commonly refused to accept applicants with even minor health problems.¹⁹² As discussed below, in instances where an innocent patient cannot be returned to the status quo ante, rescission may not be a valid remedy.¹⁹³ Though the status quo ante limitation on rescission is acknowledged by the *Hailey* court, the DMHC regulators have not incorporated this requirement in their current view of the law as it relates to health coverage rescission.¹⁹⁴

Case law has long recognized a return to the status quo ante as an essential element of the rescission remedy. Citing both California Civil Code section 1692¹⁹⁵ and a long line of California cases,¹⁹⁶ the

187. *Thompson*, 513 P.2d at 360.

188. *Hearing*, *supra* note 2, at 3.

189. *Runyan v. Pacifica Air Indus., Inc.*, 466 P.2d 682, 691 (Cal. 1970).

190. *Id.*; see also CAL. CIV. CODE § 1692 (West 2007) (“In an action . . . based upon rescission, the court may require the party to whom such relief is granted to make any compensation to the other which justice may require and may otherwise in its judgment adjust the equities between the parties.”).

191. See discussion *infra* Part III.C.

192. See discussion *infra* Part III.C.

193. See *Hailey v. Cal. Physicians’ Serv.*, 69 Cal. Rptr. 3d 789, 802 (Ct. App. 2007).

194. *Hailey*, 69 Cal. Rptr. 3d. at 802.

195. CAL. CIV. CODE § 1692.

196. *Bank of Am. v. Greenbach*, 219 P.2d 814, 827 (Cal. Ct. App. 1950); see also *Utemark v. Samuel*, 257 P.2d 656, 659 (Cal. Ct. App. 1953) (stating that the purpose of rescission is to place

California Supreme Court in *Runyan* found that “in [rescission] actions the court should do complete equity between the parties.”¹⁹⁷ The court went on to find, in language that reverberates through case law,¹⁹⁸ that “[i]t is the purpose of rescission ‘to restore both parties to their former position as far as possible’ and ‘to bring about substantial justice by adjusting the equities between the parties’ despite the fact that ‘the status quo cannot be exactly reproduced.’”¹⁹⁹ “[T]here is no requirement that the party against whom rescission is invoked be restored to the *status quo ante*.”²⁰⁰ Traditionally, whether the rescinded party must be returned to the status quo ante depends upon a weighing of the equities.²⁰¹

Under this approach, the state of mind of the party to be rescinded—for example, whether she intended to misrepresent a health condition when applying for coverage—is a key determinate of whether a party deserves to be returned to the status quo ante. As articulated in *Spencer v. Deems*,²⁰² the general rule is that a court of equity will not “decree a rescission of an executed contract unless the party desirous of effecting such rescission is able to place the defendant in statu quo.”²⁰³ However, the rule is “not without exception.”²⁰⁴

That exception is provided in cases where the party whose contract was rescinded intended to deceive the rescinding party and the rescission “is sought upon the ground of fraud.”²⁰⁵ Under those circumstances, “it would be manifestly unjust and inequitable or

the *defendants* in the status quo regardless of any loss *plaintiffs* might suffer, even if plaintiffs were entitled to be restored to their former position); *Lobdell v. Miller*, 250 P.2d 357, 367 (Cal. Ct. App. 1952) (“[T]he fact that the *status quo* cannot be exactly reproduced will not preclude the plaintiffs from equitable relief.”).

197. *Runyan v. Pacifica Air Indus., Inc.*, 466 P.2d 682, 691 (Cal. 1970) (citing *Stewart v. Crowley*, 3 P.2d 562, 565 (Cal. 1931)).

198. *See, e.g., Bank of Am.*, 219 P.2d at 827.

199. *Runyan*, 466 P.2d at 691 (citing *Bank of Am.*, 219 P.2d at 827).

200. *In re Thomas Lloyd*, 369 B.R. 549, 561 (Bankr. N.D. Cal. 2007), *aff'd*, 2008 WL 298820 (N.D. Cal.).

201. *See* CAL. CIV. CODE § 1692 (West 2007) (“If in an action or proceeding a party seeks relief based upon rescission, the court may require the party to whom such relief is granted to make any compensation to the other *which justice may require and may otherwise in its judgment adjust the equities between the parties.*” (emphasis added)).

202. 185 P. 671 (Cal. Ct. App. 1919).

203. *Id.* at 672.

204. *Id.*

205. *Id.*

impossible to apply such a rule,”²⁰⁶ and the court may “decree rescission, notwithstanding . . . [the fact that the fraudulent] party may not be placed exactly in statu quo.”²⁰⁷ Similarly, *Snelson v. Ondulando Highlands Corp.*²⁰⁸ suggests that fraud will weigh against a party in a balancing of equities and allow a rescission even if the party committing fraud cannot be returned to the status quo ante.²⁰⁹

The implication of *Runyan*, *Snelson*, and *Spencer* taken together seems to be that innocent parties whose coverage was rescinded—those who did not act fraudulently—should be returned to the status quo ante by the rescinding party. The DMHC regulators’ blanket statement that health plan contracts may be rescinded regardless of the patient’s intent or mental state, as long as precontract underwriting was “reasonable,” fails to account for the analysis required by *Runyan*,²¹⁰ *Spencer*,²¹¹ and *Snelson*.²¹²

Assuming that a court finds that a rescinded party is deserving of a return to the status quo ante—that is, the rescinded party is innocent of misrepresentation or fraud—the next question is how the status quo ante is achieved. California courts²¹³ have found that money damages, in addition to restitution of the consideration provided under the contract, are sometimes necessary to put a rescinded party back in the status quo ante.²¹⁴

206. *Id.*

207. *Id.*

208. 84 Cal. Rptr. 800 (Ct. App. 1970).

209. *Id.* at 809; *see also* *Green v. Duvergey*, 80 P. 234, 238 (Cal. 1905) (“It is not an invariable rule that the rescission of a contract obtained by fraud will be denied merely upon the ground that the parties cannot be placed in statu quo. If equity can still be done between the parties, courts will grant relief to the defrauded party.”).

210. *Runyan v. Pacifica Air Indus. Inc.*, 466 P.2d 682, 691 (Cal. 1970).

211. 185 P. at 672.

212. 84 Cal. Rptr. at 809.

213. *See, e.g.*, *Bank of Am. v. Greenbach*, 219 P.2d 814, 827–28 (Cal. Ct. App. 1950) (“Authorities are legion and uniform to the effect that the legal effect of a rescission is to restore both parties to their former position as far as possible. The authorities also agree that, concurrent with the award of rescission, the trial court may award money damages or order such other relief as justice may require. That means the return to each party, so far as possible, of the property that he parted with at the time of the settlement.” (citations omitted)).

214. *Runyan*, 466 P.2d at 690 (“Some of these cases refer to such monetary awards given in an action for rescission as ‘damages’ or ‘consequential damages.’”); *see also* 11A Cal. Jur. 3d *Cancellation of Instruments* § 54 (2008) (“[B]ecause actions for cancellation are equitable, there may be recovered, beyond the consideration parted with, compensation for whatever consequential damages the party may have suffered by reason of having entered into the transaction.”).

However, the *Hailey* court discusses the “unique challenges” that courts must confront when attempting to return an innocent patient to the status quo ante in the health coverage rescission context.²¹⁵ In fact, a return to the status quo ante may be impossible. Since a health plan coverage rescission often occurs following a major illness, rescinded patients will find it difficult, and likely impossible, to ever obtain new coverage.²¹⁶ For these patients, the status quo ante cannot be achieved. For example, patients who, like the Haileys, had the option of obtaining coverage from an employer prior to the rescission, likely no longer have that option following the rescission.

Rescinded patients who have suffered major debilitating illnesses requiring lengthy treatment and recovery, or who have permanent disabilities, like Steve Hailey,²¹⁷ may not be able to return to work immediately, if at all. If the rescinded patient does have the option of obtaining new employment-based health coverage following a rescission, or can take advantage of coverage obtained by a working spouse,²¹⁸ the status quo ante might be achieved, but only if the rescinding health plan is required to cover the patient until the employer’s health coverage enrollment period begins.²¹⁹

Other challenges of returning the rescinded patient to the status quo ante arise due to the right of the new employer’s health plan to exclude from coverage certain preexisting medical conditions for up to six months.²²⁰ Any treatment related to preexisting medical conditions would not be paid by the new health plan during that time period.²²¹ Under this scenario, the status quo ante might be achieved, but only if the rescinding health plan were required to pay for treatment related to these preexisting conditions until coverage under the new health plan is available.

215. *Hailey v. Cal. Physicians’ Serv.*, 69 Cal. Rptr. 3d 789, 802 (Ct. App. 2007).

216. *Id.*

217. *Id.* at 796–97.

218. See generally Robyn Shelton, *Sick & Fired: Is There ‘Health Discrimination’ in the Workplace?* ORLANDO SENTINEL, July 19, 2008, at A1 (reporting that businesses may fire sick employees to avoid increased health care costs).

219. State of California, *Group Coverage Through Your Job*, <http://www.opa.ca.gov/healthcare/health-plan/group-coverage.aspx> (last visited Feb. 7, 2010).

220. CAL. HEALTH & SAFETY CODE § 1357.50(b)(8)(c) (West 2007).

221. State of California, *Pre-Existing Conditions*, <http://www.opa.ca.gov/healthcare/health-plan/pre-existing-conditions.aspx> (last visited Feb. 7, 2010).

In all instances, achieving the status quo ante requires quick intervention by courts or regulators to prevent the degradation of the rescinded patient's health. Permanent injury may result due to gaps in health coverage and the patient's resulting inability to access needed treatments.²²² Even under the best-case scenario in which new coverage is available immediately from an employer, many rescinded patients may face other damages. For example, the rescinded patient's inability to obtain individual coverage may cause her to forgo early retirement or entrepreneurial ventures.

The self-employed, those working for employers that do not provide coverage, and those whose permanent injuries bar them from seeking employment will likely never be able to purchase health coverage on their own following a rescission. Individual policies, as opposed to group policies provided by employers, are purchased directly by the consumer, or through an insurance agent, from the health plan for individual or family coverage.²²³ Under state law in thirty-eight states, including California, health plans may medically underwrite such individual policies and refuse to sell coverage, even if an applicant has only relatively minor health problems.²²⁴ Asthma, acne, allergies, and arthritis are all deemed "uninsurable" conditions by major California health plans.²²⁵ In fact, health plans have unilateral control over the content and conditions of their underwriting guidelines.²²⁶

Since the recent spate of individual policy rescissions in California have often occurred following *major illnesses*,²²⁷ placing these patients in the status quo ante—a position in which the patient could purchase new individual health coverage from another health plan—is likely impossible. Serious preexisting conditions will almost certainly run afoul of another health plan's underwriting guidelines,

222. *Hailey*, 69 Cal. Rptr. 3d at 798.

223. State of California, Individual Coverage, <http://www.opa.ca.gov/healthcare/health-plan/individual-coverage.aspx> (last visited Feb. 7, 2010).

224. NCSL REPORT, *supra* note 27, at 2–3.

225. See CAL. HEALTH & SAFETY CODE § 1389.4; Press Release, Consumer Watchdog, *supra* note 31.

226. CAL. HEALTH & SAFETY CODE § 1389.4.

227. Girion, *supra* note 10, at A1 (reporting that Blue Cross designated an entire department inside the company that, upon receiving high-dollar-value insurance claims, reviews medical records and investigates a patient's insurance risk).

and therefore prohibit rescinded patients from attaining new coverage in the individual-policy market.²²⁸

Additionally, a unilateral rescission based on the mere *allegation* of fraud by the health plan bars the rescinded patient from enrolling in state-funded programs designed to provide coverage to the medically uninsurable.²²⁹ Simply returning the premiums paid by the insured does not return these patients to the status quo ante.²³⁰

Money damages are also inadequate to compensate the innocent patient whose health coverage has been rescinded. Courts would be hard pressed to calculate the value of lost future health coverage and resulting out-of-pocket costs for potentially decades' worth of uncovered medical expenses.²³¹ Further, the patient plaintiff would likely not be able to prove, with the level of certainty needed to receive expectancy damages, the value of forgoing early retirement or the lost future profits of an entrepreneurial business venture that could not be pursued.²³² What is the pecuniary equivalent of mental anguish and worry of facing future illness without insurance coverage?

Given these unique challenges of returning rescinded patients to the status quo ante, the *Hailey* court, relying on the *Runyan* court's analysis,²³³ appears to acknowledge that where both parties cannot be returned to the status quo ante, or something resembling the status quo ante, rescission may not be an appropriate remedy.²³⁴ The *Hailey* court is careful to note that its findings regarding the equitable nature of health plan rescission are not meant to signal a change in the law of rescission but "*to illustrate the backdrop of section 1389.3.*"²³⁵

228. State of California, Individual Coverage, <http://www.opa.ca.gov/healthcare/health-plan/individual-coverage.aspx> (last visited Feb. 7, 2010).

229. MRMIP ENROLLMENT UNIT, CALIFORNIA MAJOR RISK MEDICAL INSURANCE PROGRAM, 2009 APPLICATION AND HANDBOOK 2 (2009).

230. Cady & Gates, *supra* note 40, at 818–19 (2000) ("The insured . . . despite the premium refund, has lost both the opportunity to procure other insurance and the security and peace of mind for which he originally bargained."); *see also* Runyan v. Pacifica Air Indus., Inc., 466 P.2d 682, 691 (Cal. 1970) ("California courts applying general principles of equity have recognized that the restoration to the rescinding party of the consideration with which he originally parted does not necessarily in all instances restore him to his former position and bring about substantial justice.").

231. *See* JACOB A. STEIN, STEIN ON PERSONAL INJURY DAMAGES § 6.5 (3d ed. 1997).

232. *Id.*

233. *Runyan*, 466 P.2d at 691.

234. *Hailey v. Cal. Physicians' Serv.*, 69 Cal. Rptr. 3d 789, 802 (Ct. App. 2007).

235. *Id.* at 802 n.6 (emphasis added).

The suggestion is that notwithstanding Health and Safety Code section 1389.3, an innocent patient's policy cannot be rescinded if the requirements of *Runyan* cannot be met. The DMHC regulators overlook these limitations of the rescission remedy articulated in the *Hailey* decision.²³⁶

The state of mind of the patient at the time the application was completed should be a central and essential factor in determining whether rescission is an appropriate remedy in the health plan context. *Runyan*,²³⁷ together with the analysis required by *Spencer*,²³⁸ *Snelson*,²³⁹ and *Hailey*,²⁴⁰ suggests that a patient innocent of committing fraud may challenge a rescission on the grounds that the status quo ante could not be achieved. Such principles are in conflict with the broad pronouncements by regulators that rescissions may be carried out regardless of whether an omission on an application was intentional as long as the health plan completed "reasonable" precontract medical underwriting.²⁴¹

IV. PROPOSAL

California statute and supreme court precedent protect innocent patients from facing health coverage rescissions.²⁴² However, the DMHC regulators' current view of the law of health plan rescissions would allow a health plan to rescind innocent patients' coverage as long as the health plan conducted a "reasonable" review prior to issuing the policies.²⁴³

Either proposed but currently shelved regulations clarifying the legal standard for health plan rescissions should be implemented,²⁴⁴

236. *Hearing, supra* note 2, at 3.

237. 466 P.2d at 691.

238. 185 P. 671, 672 (Cal. Ct. App. 1919).

239. 84 Cal. Rptr. 800, 809 (Ct. App. 1970).

240. 69 Cal. Rptr. 3d 789, 802 (Ct. App. 2007).

241. *Hearing, supra* note 2, at 3.

242. *Thompson v. Occidental Life Ins. Co.*, 513 P.2d 353, 360 (Cal. 1973); *Runyan*, 466 P.2d at 691; *Spencer*, 185 P. at 672.

243. *Hearing, supra* note 2, at 3.

244. Draft Postclaims Underwriting Regulations, CAL. CODE. REGS. tit. 28 §§ 1300.89.1, 1300.89.3 (2006), available at <http://www.consumerwatchdog.org/resources/DraftPCUWRregs.pdf> ("No subscriber contract shall be cancelled or rescinded because of a misstatement or omission in the coverage contract, unless the misstatement or omission is a result of the applicant's willful misrepresentation and the omitted information would have been a basis

or new legislation or court action must be implemented to bring health plan rescissions in line with the fairness doctrine established by *Thompson*²⁴⁵ and *Runyan*.²⁴⁶ Simply, *Thompson* protects an innocent health insurance applicant—one who did not have the requisite state of mind to misrepresent her health information—from rescission.²⁴⁷ Equally, *Runyan*,²⁴⁸ along with *Snelson*²⁴⁹ and *Spencer*,²⁵⁰ established that the state of mind of the rescinded party—namely whether the patient intended to commit fraud—is the central factor for determining whether the remedy of rescission may be applied.²⁵¹

A. New Legislation

An alternative to reviving section 1389.3 regulations is new legislation clarifying the statutory and common law requirements and limitations of the rescission remedy. As discussed earlier, AB 1945²⁵² and its predecessor, Assembly Bill 2 (AB 2), provide one such model. Texas law provides another.

AB 2 provided that prior to rescinding coverage, the health plan must “demonstrate[] that the applicant intentionally misrepresented or intentionally omitted material information on the application . . . with the purpose of misrepresenting his or her health history in order to obtain health care coverage.”²⁵³

The AB 2 requirement that a health plan demonstrate that a patient “intentionally misrepresented or intentionally omitted” material health information would supplement section 1389.3’s current requirement for a “showing of willful misrepresentation.”²⁵⁴ This clarification was suggested by health plans, arguing that “willful

for denial of coverage pursuant to the plan’s underwriting criteria, guidelines, policies, and procedures.”).

245. 513 P.2d at 360.

246. 466 P.2d at 691.

247. *Thompson*, 513 P.2d at 360.

248. 466 P.2d at 691.

249. 84 Cal. Rptr. 800, 809 (Ct. App. 1970).

250. 185 P. 671, 672 (Cal. Ct. App. 1919).

251. See discussion *supra* Part III.C.

252. See discussion *supra* Part II.C.

253. On October 11, 2009 Governor Schwarzenegger vetoed AB 2. Assem. B. 2, 2009 Leg., 2009–2010 Reg. Sess., pg. 6–7 at section 1389.11(3) (Cal. 2009), available at http://info.sen.ca.gov/pub/09-10/bill/asm/ab_0001-0050/ab_2_bill_20090916_enrolled.pdf

254. CAL. HEALTH & SAFETY CODE § 1389.3 (West 2007).

misrepresentation” was inadequately defined in the existing law. *Willful* and *intentional* misrepresentations are seen as functional equivalents by health plan rescission experts.²⁵⁵

The AB 2 phrase “with the purpose of misrepresenting his or her health history in order to obtain health care coverage” builds on *Thompson*’s bar on rescission in cases where an insured “had no present knowledge of the facts sought, or failed to appreciate the significance of information related to him.”²⁵⁶ Simply, if an applicant failed to “appreciate the significance of information” related to her by her physician, then the patient lacked the state of mind necessary to misrepresent her health history in order to obtain health care coverage.²⁵⁷

Alternatively, Texas courts require an insurer seeking to rescind a life insurance policy to show that the insured had the “intent to deceive” the insurer.²⁵⁸ Both the Texas Supreme Court and the Fifth Circuit have held that an insurer seeking to rescind a life insurance policy must plead and prove five elements:

1. The making of a representation.
2. The falsity of the representation.
3. Reliance on the representation by the insurer.
4. The intent to deceive on the part of the insured.
5. The materiality of the representation.²⁵⁹

B. Future Court Decisions

If new legislation or regulations are not enacted, future courts should correct the DMHC regulators’ dangerous interpretation of *Hailey*.²⁶⁰ Namely, in a lawsuit in which the health plan claimed that it did complete “reasonable” medical underwriting prior to issuing

255. See DMHC Amicus, *supra* note 3, at 22 n.31. “Intentional” is defined as “done with the aim of carrying out the act.” BLACK’S, *supra* note 150, at 826 (8th ed. 2004). “Willful” is defined as “[v]oluntary and intentional, but not necessarily malicious.” *Id.* at 1630.

256. *Thompson v. Occidental Life Ins. Co.*, 513 P.2d 353, 360 (Cal. 1973); *Ransom v. Penn Mut. Life Ins. Co.*, 274 P.2d 633, 636–37 (Cal. 1954).

257. *Thompson*, 513 P.2d at 360.

258. Andrew C. Whitaker, *Rescission of Life Insurance Policies in Texas*, 59 BAYLOR L. REV. 139 (2007).

259. *Id.* at 139 n.1 (emphasis added). Alternatively, a 2008 New Mexico law bars health insurance rescissions except in instances of “willful or fraudulent misstatements.” S.B. 226, 48th Leg., 2d Sess. at 1(N.M. 2008), available at <http://www.sos.state.nm.us/2008/SBill226.pdf>.

260. *Hearing*, *supra* note 2, at 3.

coverage, a future court should build upon *Hailey* by establishing that willful misrepresentation is a prerequisite to *any* rescission under Health and Safety Code section 1389.3. Such a finding would bring health plan rescissions in line with the fairness doctrine established by *Thompson*²⁶¹ and *Runyan*,²⁶² the legislature's intent in enacting the Knox-Keene Act generally²⁶³ and section 1389.3 specifically,²⁶⁴ and the public policy pronouncements by the DMHC and by Governor Schwarzenegger.²⁶⁵

V. CONCLUSION

The DMHC regulators' overbroad interpretation of *Hailey* means that purchasing health coverage in good faith will not guarantee that a health plan will fulfill its promise to pay for health care. Under the regulators' interpretation, health plans may rescind an innocent patient's health coverage when she is sick and needs health care the most. The rescission may be carried out regardless of whether the applicant knew of or understood the health information that was allegedly omitted or misrepresented.²⁶⁶ Under the regulators' view, the state of mind of the applicant is *not* an essential factor in determining whether a rescission is rightful as long as the health plan's precontract underwriting was "reasonable."²⁶⁷ Thus, patients enrolled in HMO or PPO plans regulated by the DMHC could have their coverage rescinded even if they were innocent of misrepresentation, while those patients enrolled in coverage provided by the California Department of Insurance, apparently identical in many ways to DMHC coverage, would be protected by supreme court precedent.

Even if subsequent regulation or legislation more clearly defines what constitutes "reasonable underwriting," such a rule will not guarantee that health plan patients innocent of willful or intentional misrepresentation would be spared rescission.²⁶⁸ Such rescissions

261. *Thompson*, 513 P.2d at 360.

262. *Runyan v. Pacifica Air Indus., Inc.*, 466 P.2d 682, 691 (Cal. 1970).

263. See CAL. HEALTH & SAFETY CODE § 1342 (West 2007).

264. See *Torres*, *supra* note 50 and accompanying text.

265. See *supra* notes 3 and 17.

266. *Hearing*, *supra* note 2, at 3.

267. *Id.*

268. See discussion *supra* Part III.C.

supported by “reasonable” underwriting conflict with California Supreme Court doctrine protecting innocent insurance patients from actions to void a contract.²⁶⁹

In addition to contradicting *Thompson*, which bars the use of innocent mistakes to void a policy,²⁷⁰ the DMHC regulators’ overly broad reading of *Hailey*²⁷¹ violates common law principles. In *Runyan*, the California Supreme Court canonized common law restrictions on rescission in instances where the rescinded party cannot be returned to the status quo ante.²⁷² Other, older California cases applying this doctrine demonstrate that parties innocent of fraud must be returned to the status quo ante, or something resembling the status quo ante—for example, a position where they may obtain health coverage from another health plan—which is often impossible in the context of health coverage rescissions, as noted by the *Hailey* court.²⁷³ Where patients innocent of fraud cannot be returned to the status quo ante, rescission may not be an appropriate remedy.²⁷⁴

Twenty-two million California patients enrolled in DMHC-regulated health plans potentially face coverage rescissions though they intended no misrepresentation when completing enrollment applications.²⁷⁵ The DMHC regulators’ view of the current law governing health plan rescission conflicts with supreme court doctrine and common law precedent applicable to health insurers that must be rationalized to provide parity under the law. Simply, rescission should be barred if a patient did not intentionally or willfully misrepresent²⁷⁶ a health condition when applying for coverage.²⁷⁷

269. *Thompson v. Occidental Life Ins. Co.*, 513 P.2d 353, 360 (Cal. 1973); *Runyan v. Pacifica Air Indus., Inc.*, 466 P.2d 682, 691 (Cal. 1970).

270. *Thompson*, 513 P.2d at 360. Failing to disclose health information does not provide a basis for voiding a policy if the applicant “had no present knowledge of the facts sought, or failed to appreciate the significance of information.” *Id.*

271. *Hearing*, *supra* note 2, at 3.

272. *Runyan*, 466 P.2d at 691.

273. See discussion *supra* Part III.C.

274. *Id.*

275. See *supra* note 1.

276. *Thompson v. Occidental Life Ins. Co.*, 513 P.2d 353, 360 (Cal. 1973).

277. *Runyan*, 466 P.2d at 691; see also *Snelson v. Ondulando Highlands Corp.*, 84 Cal. Rptr. 800, 809 (Ct. App. 1970) (“In an action predicated on fraud, the fact that the parties cannot be restored to the exact Status quo ante will not prevent a court of equity from granting

This change would bring health plan rescissions into line with the supreme court fairness doctrine established by *Thompson*²⁷⁸ and *Runyan*,²⁷⁹ the legislature's intent in enacting the Knox-Keene Act generally²⁸⁰ and section 1389.3 specifically,²⁸¹ and the public policy pronouncements by the DMHC and by Governor Schwarzenegger.²⁸²

rescission . . ."); *Spencer v. Deems*, 185 P. 671, 672 (Cal. Ct. App. 1919) (finding rescission appropriate when the defendant knowingly made a material misstatement, even if the defendant could not be fully placed in the status quo).

278. *Thompson*, 513 P.2d at 360.

279. *Runyan*, 466 P.2d at 691.

280. See CAL. HEALTH & SAFETY CODE § 1342 (West 2007).

281. See *Torres*, *supra* note 50 and accompanying text.

282. See *supra* notes 3, 17.

