

Court says insurance company's 'wait and see policy' violates California law

The Hailey *decision may allow more cases to go to trial to contest post-claim underwriting*

Maria Pecot

Health insurance is on everyone's mind these days. It has become a focal point in the campaigns of the leading Democratic presidential candidates. Even Republican runners with conservative agendas are touting health-care reforms.

A November 2007 Gallup Poll reported that 81 percent of Americans are dissatisfied with the cost of health care in the country and 73 percent of people thought that the American health care system was in a state of crisis or had major problems. Movies, like Michael Moore's *SiCKO*, present frightening and disturbing worst-case scenarios where health-care companies have failed their insured, sometimes leading to suffering and deaths.

Health care in this country is perhaps most frightening, because it's not just the poor and uninsured who are not getting proper health care. Middle class people and insured workers, who believe they have adequate coverage, are being denied access to health care by their policies, when they become sick or injured.

Post-claim underwriting

The practice of post-claim underwriting – when an insurance company investigates a policyholder's application for omissions and inaccuracies, *after* a claim is filed – has been going on for a long time and is in violation of California law, says Bill Shernoff, a plaintiff's attorney in Claremont who specializes in bad-faith insurance law. As Shernoff contends, Health and Safety Code section 1389.3 clearly prohibits the rescission of a plan due to the "plan's failure to complete all medical underwriting and resolve all reasonable questions derived from written information on or within an application before issuing a contract."

The law was designed to prevent people from losing coverage when they need it the most. Particularly, because once someone has a major medical problem on his or her record, it is nearly impossible to obtain a new policy.

In recent years, there has been a surge of bad-faith insurance cases arising from post-claim underwriting. Despite the law, the courts have typically sided with defense attorneys who argue that post-claim underwriting is not the same as a post-claim investigation. Almost all cases having to do with post-claim underwriting are thrown out in the pre-trial phases.

The changes after *Hailey*

California's 4th District Court of Appeal may have changed all that. In *Hailey v. the California Physicians' Service* (Jan. 22, 2008, G035579) ___ Cal.Rptr.3d ___ [2008 WL 186145], Division Three in Santa Ana court ruled that health insurance companies such as California Physicians' Service, a subsidiary of Blue Shield, have to initially investigate whether consumers are eligible for policies, rather than collect premiums, and wait until the policyholder files a claim. According to

William Shernoff, the attorney quoted in this article, represents 6,000 potential class members in a post-claim underwriting suit against Blue Cross of California, *Horton v. Wellpoint, BC341823* (Los Angeles Superior Court, filed 10/24/05). In May 2007 he reached a much-heralded and debated settlement with Blue Cross in which that company agreed to revise its policy of cancelling individual health coverage after its policyholders make a claim, the rescissions being based on alleged errors in the policyholders' applications. The settlement, which was subject to court approval, also outlined a grievance process for policyholders to protest rescission of their contracts. Unexpectedly, Blue Cross and its parent company, Wellpoint, filed a motion in January to squelch the settlement before it could be approved by the court and asked that the case be ordered to arbitration. A hearing on the Blue Cross motion was scheduled for March 7.

According to lawyers familiar with the case, the motion could have several outcomes: Certify a class and schedule a trial; compel Blue Cross to honor the settlement; order the matter to arbitration as Blue Cross requested; or kill the settlement and at the same time order that 6,000 potential class members be notified that they have the right to sue individually. – Editor

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the *Hailey* ruling, insurance companies must prove that an applicant willfully misrepresented information on the application to rescind a policy.

The case, which was previously dismissed by a lower court, involves Steve Hailey, a small business owner from Orange County, and his wife, Cindy. In 2001, Steve was involved in a major car accident. Initially, his medical bills were covered under a Blue Shield policy that Cindy had enrolled him in. Once his medical expenses reached $450,000; however, Blue Shield canceled his coverage and demanded that he repay over $104,000.

Blue Shield accused the Haileys of omitting a slew of health problems from their application, and underreporting Steve's weight by about 50 lbs. Cindy, who filled the application out for herself, her husband and their teenage son, said the application did not ask about her husband and son's health histories, only her own. She said the lack of clarity in the application instructions led to the alleged omissions.

The court agreed that Blue Shield's application was written in a way that could cause confusion. In an opinion written by Justice Richard M. Aronson, the court said the application, "although understandable upon close examination and reflection, is no model of clarity, and lends credence to Cindy's explanation of her omission of Steve's health information."

Blue Shield first looked into Steve's medical records in February of 2001, two months after they issued the family's policy. Steve had been hospitalized for stomach problems, and that claim prompted Blue Shield underwriters to conduct an investigation. His prior medical records revealed he had a history of obesity and hypertension. Six weeks later he was involved in the car accident. The day after he was released from the hospital, Blue Shield canceled his policy.

Cindy says that if Blue Shield had contacted her in February, when they first noticed a problem with the application, she could have secured health coverage for her husband and her son through her employer, well before the accident occurred.

Steve Hailey sustained a torn urethra and other injuries from the collision. After Blue Shield canceled the Haileys' policy, the family could not afford the rehabilitative services and other vital medical care Steve needed. A badly needed operation was delayed until the condition became life-threatening. To save his life, Steve finally got the operation, but at that point he had become permanently disabled. He now relies on a catheter to empty his bladder, and he is no longer able to work, the Haileys said.

Only one percent of every 1,000 policies that Blue Shield investigates for application omission and misstatements are canceled. Blue Shield used this fact in their defense, but the court was not persuaded. "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 after the claims submitted under the contract exceed the monthly premiums being collected," the court stated.

The court also noted that, "Assuming the truth of the Hailey's evidence, the tragic situation that they now find themselves in could have been averted, had Blue Shield's agent or underwriter simply asked Cindy if she had included information about her husband and son." The court's ruling will allow the Haileys to bring their case in front of a jury.

What is the real cost?

Blue Shield spokesman, Tom Epstein, says that requiring insurance companies to investigate every question on the application before issuing a policy would create a lot of unnecessary work. According to Epstein, such a requirement would lengthen the application process and make insurance even more expensive for consumers.

Shernoff, who filed an *amicus curiae* brief in the *Hailey* case, says that these types of arguments have long been used by insurance companies and that he "has a hard time accepting this sort of explanation because they (the insurance companies) make so much profit." Last quarter, Wellpoint – Blue Cross of California's parent company – hit profits of $859.1 million. Shernoff says they would only have to spend a few million dollars to follow the law and do the proper underwriting before approving applications and collecting premiums from policyholders.

Shernoff says that the *Hailey* case is a huge victory because the milestone ruling will allow more of these types of cases to go to trial. This would give plaintiffs more power, leading to heftier settlements and possible punitive damages.

And while the Haileys and their lawyer, Michael Nutter, are happy about the court's decision, they will have to wait and see if the ruling sticks. On February 5, 2008, Blue Shield filed a petition for review with the California Supreme Court.

Maria Pecot grew up in the Bay Area and attended the University of California Berkeley, where she earned her Bachelor's degree in Political Science with a focus on American Politics. She currently works as a freelance writer, fashioning articles on a wide array of subjects. She lives in Oakland.

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