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## California Appellate Decision Affirms Right of Health Insurers to Rescind Policies for Misrepresentation

The continuing debate about retroactive cancellation of individual health insurance policies in California has just been clarified. In a decision issued on January 19, 2010, in *Nieto v. Blue Shield of California Life & Health Ins. Co.*, Appeal No. B214669, the California Court of Appeals for the Second Appellate District affirmed a summary judgment in favor of Blue Shield ruling that the insurer was entitled to retroactively cancel or rescind a policy of insurance based on material misrepresentations and omissions about the applicant's health history made on the application for the insurance even though the insurer had neither endorsed nor attached the application to the policy of insurance when issued as required by Insurance Code sections 10133<sup>1</sup> and 10381.5.<sup>2</sup> (Slip Opinion at p. 2.)

### The Application

In the "Medical History" portion of the application, plaintiff Nieto, and her domestic partner, Moore, answered "no" to nearly every question. Nieto and Moore answered "yes" to the question about whether any applicant had in the past 20 years received treatment, including medications, for symptoms pertaining to the "Musculo-skeletal system – such as: neck, spine/back sprain, pain, injury, sciatica, herniated or bulging disc(s), or problems . . . ." In the section requesting information about any "yes" answer, Moore responded that he had been diagnosed with a bulging disc lasting from October 1995 to July 2000, but that the condition no longer existed. Nieto provided no additional information in response to this question. Nieto also answered that her last doctor's visit had occurred approximately three years earlier when she sought treatment for the flu. But she answered "no" to the question asking whether she had been ordered to take any prescription medications during the previous 12 months. Nieto signed the application directly below an attestation that read as follows: "I have read the summary of benefits and the terms and conditions of coverage and authorizations set forth above. I understand that neither I, nor any family members, will be eligible for coverage if any information is false or incomplete. I also understand that if cover-

age is issued, it may be cancelled or rescinded upon such a finding." (*Id.* at pp. 4-5.)

The sales agent received the application, and subsequently contacted Nieto and Moore seeking information that was missing from the application. The sales agent subsequently submitted the application to a Blue Shield underwriter, who instructed the application department to send Nieto an addendum to the application requesting information about her last doctor's visit. After receiving the completed information, the health insurance policy was issued to Nieto and Moore effective July 1, 2005. (*Id.* at p. 5.) On September 30, 2005, Blue Shield opened an investigation after it received a referral from the Medical Management Department that Nieto had receive a diagnosis of necrosis of the hip and was scheduled for hip replacement surgery on November 10, 2005. Blue Shield subsequently obtained Nieto's medical and pharmacy records. Blue Shield learned that immediately preceding her application, Nieto had received extensive treatment for back and hip pain and had been prescribed multiple medications. By letter dated November 16, 2005, Blue Shield rescinded the subject policy on the basis of material misrepresentations and omissions on the application for the insurance. (*Id.* at pp. 5-6.)

### The Trial Court Granted Summary Judgment to Blue Shield

Nieto sued Blue Shield in July 2006 asserting causes of action for breach of contract, breach of the implied covenant of good faith and fair dealing, declaratory relief and violation of the Unfair Competition Law, California Business and Professions Code section 17200. Nieto alleged that the rescission of her policy constituted unlawful post-claims underwriting in violation of California Insurance Code section 10384 and was an unreasonable use of her insurance application in violation of Insurance Code section 10381.5. Nieto sought compensatory and punitive damages as well as declaratory and injunctive relief. Blue Shield answered and cross-complained against Nieto alleging she made material false representations and omitted material medical information in her application for the insur-

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ance. Blue Shield sought a declaratory judgment that it rightfully rescinded the policy. (*Id.* at p. 6.)

The trial court granted Blue Shield's summary judgment motion in November 2008. The trial court ruled that Nieto's application contained a number of material false representations and omissions concerning her health history; Nieto was either aware the representations were false or exhibited a reckless disregard for the truth; appellant made the representations to cause Blue Shield to issue the policy, that Blue Shield relied on the false statements and omissions in the application in issuing the policy; and that had Blue Shield known the true facts, it would not have issued the policy. The trial court rejected Nieto's assertion that Blue Shield had engaged in post-claims underwriting contrary to Insurance Code section 10384, explaining that Blue Shield had properly completed underwriting and resolved all reasonable questions arising from the information supplied in connection with the application before issuing the policy. The trial court found that there was nothing on the application to alert Blue Shield that any of the responses were false. The trial court also concluded that whether Blue Shield had attached or endorsed the application to the policy had no bearing on its ability to rescind in view of Nieto's material misrepresentations and omissions. (*Id.* at p. 8.)

### **The Court of Appeal Affirmed the Summary Judgment Order Based on Fraud**

The Second District Court of Appeals affirmed the summary judgment issued in favor of Blue Shield. The Court of Appeal agreed that the undisputed evidence supported that Nieto had committed fraud by making material misrepresentations or omissions concerning her health history to Blue Shield before it issued the policy. (*Id.* at p. 15.) In support of its decision, the Court cited Insurance Code section 332 which requires that parties to a contract of insurance communicate to the other in good faith all facts within

their knowledge material to the contract. The Court of Appeal also added that the summary judgment was equally proper on the ground of misrepresentation, citing Insurance Code section 359 that permits the injured party to rescind a contract of insurance based on a material false representation. (*Id.* at p. 16.) The court noted that Nieto had represented that her last doctor's visit was three years prior to submitting her application, when she had seen one physician 17 times between February and May 2005, including on the day she signed the application. She had also received 10 prescriptions for four medications and received steroid injections and oral medications during the same period. (*Id.* at p. 17.)

### **The Court of Appeal Rejected Plaintiff's Argument that Blue Shield's Failure to Attach the Application to the Policy Barred Rescission**

Nieto argued that even if the undisputed evidence established she made material misrepresentations and omissions on the application, Blue Shield was barred from rescinding the policy because it had neither attached nor endorsed the application to the policy as required by Insurance Code sections 10133 and 10381.5. Nieto relied on *Ticconi v. Blue Shield of California Life & Health Ins. Co.* (2nd Dist. 2008) 160 Cal.App.4th 528, where the Court reversed an order denying class certification on the ground that individual issues of fraud would not predominate over common issues related to liability. It reached its conclusion by construing sections 10133 and 10381.5 "to preclude an insurer from raising the defense of fraud based on statements that an insured made in an application for insurance if the application had not been attached or endorsed on the policy when issued [citations]." (*Id.* at p. 534.) But in *Nieto*, the Court of Appeal affirmed the decision of the trial court that application of sections 10133 and 10381.5 did not preclude rescission based on fraud and deceit. (Slip Opinion at p. 21.) The Court of Appeal noted that section 10133 only applied "in the absence of fraud." (*Id.* at

p. 22.) The Nieto Court also noted that the Court in *Ticconi* ruled that a court could consider the insured's application misstatements regardless of whether the insurer attached or endorsed the application when determining equitable remedies – like rescission. (*Id.* at p. 22.) For these and other reasons, the Court of Appeal concluded that "we decline to adopt the blanket conclusion in *Ticconi* that material misrepresentations and omissions in an application which is not physically attached to a policy may not be relied upon by the insurer to rescind the policy." (*Id.* at p. 23.)

### **The Nieto Court Specifically Ruled that Blue Shield Had Not Engaged in Post-Claims Underwriting**

The Court of Appeal also affirmed the trial court's finding that Blue Shield had not engaged in "post-claims underwriting" in violation of Insurance Code section 10384.<sup>3</sup> (*Id.* at p. 25.) The trial court ruled that Blue Shield had not engaged in post-claims underwriting because the undisputed facts established that Blue Shield properly completed underwriting and resolved all reasonable questions arising from the written information submitted on or with the applications; and that even if one were to assume that Blue Shield had a duty to contact the healthcare providers listed on the application, Nieto did not even list the providers who had treated her for the conditions that led to the rescission. Relying on *Hailey v. California Physicians' Service* (4th Dist. 2007) 158 Cal.App.4th 452, Nieto asserted there were triable issues of fact concerning whether Blue Shield reasonably completed medical underwriting prior to issuing the policy. *Hailey* involved an interpretation of California Health and Safety Code section 1389.3 which prohibits pre-paid health care service plans licensed under the Knox-Keene Health Care Service Plan Act (Cal. Health & Saf. Code, § 1340 et seq.) from engaging in post-claims underwriting. The statute is phrased similarly to section 10384, but does not apply upon a showing of willful misrepresentation. (Slip Opinion at p. 25.)

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In *Hailey*, the insured completed a Blue Shield application, mistakenly believing the application sought information only about her and not her husband and son who also sought coverage. She also had incorrectly estimated her husband's weight. After Blue Shield issued the policy, the husband was admitted to the hospital with stomach problems and later became totally disabled as a result of an automobile accident. (*Hailey, supra*, 158 Cal.App.4th at p. 461.) Following the first hospitalization, Blue Shield rescinded the policy on the basis that the insured had misrepresented and omitted material information about her husband's medical condition on the application. (*Id.* at pp. 461-462.) Hailey sued for breach of contract and bad faith, but the trial court granted summary judgment to Blue Shield on the basis of the misrepresentations and omissions on the application. The Fourth District Court of Appeals reversed the ruling that there were triable issues of fact as to whether Blue Shield had engaged in post-claims underwriting and whether the insured willfully misrepresented her husband's medical condition. The appellate court in *Hailey* concluded that "to effectuate section 1389.3's purpose, and in light of the equitable nature of rescission, we interpret 'medical underwriting' to require a plan to make reasonable efforts to ensure a potential subscriber's application is accurate and complete." (*Id.* at p. 469.)

The Court of Appeals in *Nieto* concluded that even if it were to apply *Hailey* to the evidence offered in support of summary judgment, the undisputed facts established that Blue Shield's underwriting process included appropriate steps to ensure the accuracy and completeness of the application. Multiple Blue Shield employees contacted Nieto to obtain information missing from the application that raised concerns. The Court noted that Blue Shield had checked its own claims database and confirmed that Nieto had no prior claims history. The Court also pointed out that Nieto had offered no evidence that the rescission resulted from Blue Shield's failure to complete medical underwriting. (Slip Op. at pp. 27-28.)

### What Does the Decision in *Nieto* Mean to Health Insurers?

The *Nieto* decision confirms that California health insurers may rescind individual policies of insurance based on willful material misrepresentations or omissions contained on the application for insurance whether the application was attached to or endorsed on the policy that was issued. *Nieto* also stands for the proposition that health insurers may rely on information in the application for insurance if the information submitted does not raise any issues concerning the health status or history of the applicants. *Nieto* also stands for the proposition that health insurers do not commit post-claims underwriting if they make reasonable inquiries of the applicant about issues that arise from information contained on the application and by checking available claims information in their possession for any relevant claims history prior to issuing the coverage.

### Endnotes

- 1 Section 10133 requires that every contract of life or disability insurance shall be deemed to contain and constitute the entire contract between the parties and nothing shall be incorporated therein by reference.
- 2 Section 10381.5 provides, in pertinent part, that the "insured shall not be bound by any statement made in an application for a policy unless a copy of such application is attached to or endorsed on the policy when issued . . . ."
- 3 Section 10384 prohibits an insurer from engaging in post-claims underwriting defined as "the rescinding, canceling, or limiting of a policy or certificate due to the insurer's failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the policy or certificate."

### About the Author

Peter Roan is a partner at Locke Lord. He focuses on business litigation in the health care and insurance industries.