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Significant Changes to Rescission of Health Insurance Policies in California

Rescission of health insurance policies occurs where an insurer cancels existing coverage on the grounds that the insurer was misled in issuing the policy. In the past, we have reported on an increased number of rescissions—compounded by egregious results to insureds—that has increased scrutiny by regulators, doctors and plaintiffs' lawyers, who have all described insurers as too quick to rescind coverage for ill insureds. The issue of rescissions of health care policies has attracted national attention in the health care debate and increased attention in a number of states. See "[Significant Changes to Rescission of Health Insurance Policies in Illinois](#)," (April 2, 2010) and "[California Appellate Decision Affirms Right of Health Insurers to Rescind Policies for Misrepresentation](#)," (January 22, 2010).

With the Patient Protection and Affordable Care Act (HR 3590) (the "Federal Act") signed into law on March 23, 2010, Congress and President Obama have enacted the most sweeping reform of the U.S.' health care system since the creation of Medicare in 1965. One such sweeping provision in the Federal Act, which will soon be effective on September 23, 2010, prohibits rescissions of health insurance policies—except in instances of fraud and intentional misrepresentation of material facts. Some states, such as California, are not relying on the Federal Act but are implementing their own far-reaching regulations to curb rescissions.

Changes in California

Currently, California health insurers may rescind policies only under specific, limited circumstances. The new regulations, highlighted by California Insurance Commissioner Steve Poizner (the "Commissioner") and the California Department of Insurance (the "California Department"), include the following changes (effective August 18, 2010) intended to prevent insurers from cancelling health insurance policies:

- Prohibition against insurers rescinding policies when they are not in compliance with specified underwriting practices regulations;
- Restriction of health condition and history questions on applications to those that are necessary for medical underwriting. The California Department has instructed insurers to make the period of time covered by a question "as short as possible." The period must be limited to time periods required by sound actuarial underwriting standards used by the insurer;
- Requirement that all questions on health insurance applications be clear, specific, unambiguous and understandable. The regulations require that insurers use a "reasonable lay person standard" when asking about an applicant's health;
- Requirement that insurers use a new health history questionnaire approved by the California Department before rescission;
- Allow consumers to indicate that they are unsure of, or cannot remember, the answer to a particular health history question. Each applicant must have the opportunity to indicate if they are unsure of the answer, do not know how to respond to any individual health history question, or do not understand the question. Health history questions must offer response choices in addition to YES or NO, such as Not Sure;
- Requirement that agents attest if they help applicants with a health insurance application;
- Prohibition against confusing phrasing of application questions such as double-negatives and certain compound questions;
- Requirement that consumers be given a copy of their application to check for discrepancies;
- Requirement that insurers not rely solely on self-reported health history, when possible;
- Prohibition against insurers conducting certain rescission-focused investigations well after becoming aware of a possible misrepresentation or omission by the applicant. The regulations also prohibit

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Significant Changes to Rescission of Health Insurance Policies in California (cont'd.)

insurers from seeking information outside the scope of such investigation;

- Requirement that insurers give consumers the opportunity to respond during rescission investigations, and that insurers must listen to consumer-provided information;
- Requirement that insurers identify and resolve any reasonable questions arising from the application. Insurers must document their effort to resolve such issues and make the documents available to the Commissioner; and
- If an insurer learns that an insured might have left out material information or provided a misrepresentation, the insurer must start an investigation within 15 days and complete the investigation within 90 days. The insurer must send the insured a notice about the investigation every 30 days and send a written notice about the final determination within seven days of concluding the investigation. The written notice must instruct the insured whose policy is rescinded that they may have a review by the California Department.

complying with regulatory changes at both the state and federal levels.

Changes at the Federal Level

Beginning September 23, 2010, the Federal Act will prohibit rescissions of group health insurance policies except in instances of fraud and intentional misrepresentation of material fact. In addition, on that date insurers will be prohibited from denying claims for children in group plans under the age of 19 because of a preexisting condition. This restriction will apply to those 19 and over on January 1, 2014.

The reforms in the health care area represent the most significant health care reforms in over four decades, and the impact on insurers and policyholders should not be underestimated. The complex federal legislation and its interplay with pending and enacted reforms at the state level continue to create one of the more challenging regulatory environments in decades. Insurers should understand both the scope and timing of the changes. We will continue to follow and analyze the impact of these reforms in assisting our clients in

About the Authors

R. Dean Conlin is a partner at Locke Lord. He has more than 30 years of experience in a wide range of health care, insurance regulatory and corporate matters. Mr. Conlin has focused on managed health care since the early stages of preferred provider networks. His clients include regulated insurers and alternative risk vehicles that provide managed health care coverage. His work for these clients, including preferred provider organizations, has ranged from product development to regulatory counseling, including counseling on the impact of ERISA on managed health care. In addition, Mr. Conlin has organized insurers and reinsurers and counseled them on a full range of regulatory and corporate issues. In this connection, he leads our firm's longstanding representation of Old Republic International Corporation and American Fuji Fire and Marine Insurance Company. He also counsels Lloyd's Illinois, Inc., which is the corporate Illinois Attorney-in-Fact for Underwriters at Lloyd's, London.

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