POST-CLAIM UNDERWRITING:
A LIFE & HEALTH INSURER’S RIGHT
TO INVESTIGATE OR BAD FAITH?

Gary Schuman

I. INTRODUCTION

One of the most challenged and controversial issues in life, health, and dis-
ability insurance continues to be whether an individual’s misrepresentation
made in an application for coverage entitles the insurer to rescind the policy.
This issue will only grow in importance as more people join the individual
insurance market.¹ People buy individual policies because their employer
does not offer health insurance; because they retire before Medicare eligi-
bility; or because they are self-employed, between jobs, or jobless. Unlike
employer-based group coverage, which is guaranteed to all eligible employ-
ees regardless of health, individual insurance policies are not guaranteed
and are medically underwritten. This means that insurers choose their ins-
sureds based on the status of their health and their disclosure of preexisting
medical conditions.²

¹ Health Plans Lose Members Due to Layoffs, WALL ST. J., Apr. 23, 2009, at B2. Going It
Alone When Buying a Health Policy, WALL ST. J., June 24, 2009, at D1. The number of people
purchasing individual coverage continues to grow. McKinsey & Company conducted a survey
and estimated that 19.6 million people currently own individual policies. Picking a Health Plan

Gary Schuman is senior litigation counsel at Combined Insurance Company of America,
Glenview, Illinois. The views and opinions contained in this article are solely those of the
author.
As an industry, life, health, and disability insurance companies are permitted to select their risks and to deny or restrict coverage. This risk analysis is built upon responses to application questions regarding applicants’ medical history, as well as their employment, social activities, and earnings history, depending on the type of coverage being sought. Thus, people with health problems may end up paying higher premiums, face exclusions for past or existing medical conditions, or even be denied coverage. To avoid such restrictions or exclusion from coverage, some individuals will not disclose medical conditions on the application. This may result in coverage being rescinded once the insurer learns the truth.

Rescission of coverage because of application misrepresentations is an important issue for consumers who buy their own coverage. This is especially so because most often an insurer first learns of the misrepresentation when a claim is filed, a time that the insured most needs this coverage.

5. One of the basic principles of insurance is that each individual insured should pay a premium that is proportionate to the amount of risk the company assumes for that person. Employees’ Benefit Ass’n v. Grissett, 732 So. 2d 968, 978 (Ala. 1998).
6. The requirements that an insurer must establish in order to rescind a policy are governed by the state law where the particular policy was sold. See, e.g., Thorpe v. Banner Life Ins. Co., 632 F. Supp. 2d 8, 12 (D.D.C. 2009). All states require an insurer to prove that there was a misrepresentation contained on the application, that the misrepresentation was material to the risk or hazard assumed by the insurer, and that the insurer reasonably relied thereon. See Misrepresentations in the Life, Health and Disability Insurance Application Process: A National Survey (Joseph Hamilton ed., ABA Publishing 2009); infra notes 37–42 and accompanying text. States, however, differ on whether an insurer may rely on an individual’s innocent misrepresentation (New York law) or whether the insurer must establish that the insured’s misrepresentation was knowingly made (Colorado law) or whether the insurer must submit an application made with the actual intent to deceive or recklessly made with a disregard for the truth of the fact set forth on the application (Kansas law). Compare United Nat’l Ins. Co. v. Granoff, Walker & Forlenza, P.C., 598 F. Supp. 2d 540, 547 (S.D.N.Y. 2009), with W. Coast Life Ins. Co. v. Hoar, 558 F.3d 1151, 1157 (10th Cir. 2009), with Kennedy v. N. Am. Co. for Life & Health Ins., No. 08-2175-JWL, 2009 WL 1374270, at *5 (D. Kan. May 15, 2009). The author’s premise for this article is that as long as the insurer satisfies the specific statutory and common law requirements of the particular state’s law governing the rescission decision, the insurer’s post-claim investigation is valid.

Insurance plans governed by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001 et seq., less frequently involve rescission issues because coverage is often issued without medical underwriting through employer-sponsored group major medical, disability, and life insurance plans. The issue does arise, however, because even ERISA plans often underwrite supplemental life coverage as well as coverage sought by late entrants. Even then, however, the applicable state law requirements where the plan participant resides will likely control. Johnson v. Conn. Gen. Life Ins. Co., 324 F. App’x 459, 463 (6th Cir. 2009).

Many consumer advocates complain that the insurers abuse this right to rescind. Insurance applications are, according to these critics, overly detailed and confusing; and these critics contend that individuals can make honest mistakes in completing these forms. The issue is whether these insureds should be penalized for such errors. By relying on these misstatements to cancel coverage, insurers are simply attempting to avoid paying large claims.

Insurance companies respond by saying that by revoking coverage when misrepresentations are found in the application, even at claim time, “they are protecting the integrity of the underwriting process and keeping coverage affordable for customers.”

“The controversy [surrounding] rescission[] comes at a time when many Americans are demanding an overhaul of the U.S. health-care system.” As stated in the Wall Street Journal, there is “a growing furor over retroactive policy cancellations that have saddled patients with big medical bills and sparked lawsuits.” The article goes on to say that “[s]uch cases have cast an unflattering light on insurers’ practices of investigating individual’s medical histories after they get sick.”

In this regard, an insurance company practice once again coming under increasing scrutiny is what plaintiff lawyers characterize as “post-claim underwriting.” Here, plaintiff attorneys argue that insurers, instead of thoroughly investigating an applicant’s health history and, if appropriate, rejecting an applicant at the time coverage is applied for, simply issue

9. Id. at 799, 805. These misrepresentations may be innocent or intentional, depending on the particular state law. See supra note 6.
10. Rhonda L. Rundle, Health Insurers Address Issue of Nixed Policies to Counter Negative Publicity, Industry Pushes Plans to Let People Appeal Cancellations, Wall St. J., Feb. 27, 2008, at D1; see In re Tri-State Armored Servs., No. 06–226, 2007 WL 1196558, at *12 (D.N.J. Apr. 23, 2007). Insurance fraud manifests itself in many forms, including consumer fraud through misrepresentations and omissions on health insurance applications. Thomas D. Musco & Kathleen Fyffe, Health Insurers’ Anti-Fraud Programs, Research Findings 1999, at 8–9 (Health Ins. Ass’n of Am., Washington, D.C., 2000), available at www.ahipresearch.org/PDFS/22_FRAUDREPORT.pdf. A federal district court recently addressed this issue as follows: “[The insurer’s] actions highlight a basic dilemma in the law of insurance. On the one hand, the law recognizes that an insurer is entitled to accurate information concerning the risk it assumes in issuing a policy. Insurance is the business of pricing risks and it cannot function efficiently if the insured conceals or misrepresents the risks a policy covers. On the other hand, there is a strong equitable argument against rigid application of the law of misrepresentation to life [and health] insurance policies. As a California court has noted, ‘[i]t is patently unfair for a claimant to obtain a policy, pay his premiums and operate under the assumption that he is insured against a specific risk, only to learn after he submits a claim that he is not insured, and therefore, cannot obtain any other policy to cover the loss.’” Lin v. Metro. Life Ins. Co., No. 1:07-cv-03218-RJH, 2009 WL 806572 at *2 (S.D.N.Y. Mar. 30, 2009) (quoting Hailey v. Cal. Physicians’ Serv., 158 Cal. Ct. App. 4th 452, 564 (2007)).
12. Id. at D2.
coverage based on application responses and investigate the accuracy of the application responses only after a claim is filed with the intent of voiding coverage and avoiding payment of the claim. These advocates contend that this conduct should be declared illegal.

These arguments of illegality simply miss the point. There must be a balance between when an insurance company has the legal right to rely on the truthfulness of representations made by individuals on their applications for insurance and when insureds can assert post-claim underwriting as a valid defense to their misrepresentations. The ultimate issue becomes who should bear the cost for an insured’s misrepresentations: the individual insured making the misrepresentation or the insurance industry and consumers in the form of increased loss ratios and premiums.

This article first will examine the purpose and importance of the application in the insurance process as well as its role in not only the underwriting but also the claims process. The arguments raised by policyholder attorneys that an insurer acts in bad faith by performing its risk assessment of the insured only after a claim is filed instead of when the application was received will then be discussed. The case support for these arguments also will be analyzed. This article then contrasts the plaintiffs’ post-claim underwriting arguments with the insurance industry’s position and recent court decisions that support an insurer’s ability to engage not in post-claim underwriting but in post-claim investigations and, when necessary, rescind coverage. Post-claim underwriting recently has become an especially

13. First Colony Life Ins. Co. v. Sanford, 480 F. Supp. 2d 870, 875 (S.D. Miss. 2007); Hailey, 69 Cal. Rptr. 3d at 799. Stories in the media frequently are set forth regarding insurance companies challenging the validity of health coverage only after a significant claim is filed. For example, as reported in the Wall Street Journal, an individual, having for many years been covered under employer-sponsored medical plans, opened his own business and secured an individual health insurance policy. Working the System: One Cancer Patient’s Story, Wall St. J., Dec. 29, 2009, at D1. Soon thereafter, he was diagnosed with a rare and aggressive form of cancer. The article noted that “as [the insured] recovered, the bills stacked up. [The insurer] wasn’t making any payments. . . . Instead, the insurer demanded . . . the names and addresses of every doctor [the insured] had seen for the previous five years, so it could verify that he hadn’t concealed the cancer when he bought the policy. The investigation dragged on for months, until [the insured] called the insurer and warned that the next contact would be from his lawyer. Soon after . . . [the insurer] paid.” Id.


15. The ability to measure risk correctly is “the touchstone of an insurance contract.” Verex Assurance, Inc. v. John Hanson Sav. & Loan, 816 F.2d 1296, 1302 (9th Cir. 1987). Proper underwriting ensures that each proposed insured receives an equitable consistent evaluation and, if accepted, is charged an appropriate premium for the coverage offered. In other words, each insured should pay a premium that is proportionate to the amount of risk the company assumes for that person. Employees’ Benefit Ass’n v. Grissett, 732 So. 2d 968, 978 (Ala. 1998).
important issue in California, and this state’s recent case decisions will be reviewed.

The conclusion reached, even considering public policy issues raised by policyholder attorneys and the negative meaning attached to post-claim conduct by insurers, is that in most circumstances an insurance company should be entitled to rescind a life, health, or disability insurance policy based on an insured’s material misrepresentations in the insurance application and on the applicable controlling state law. This is true even when the first time that an insurer conducts an eligibility investigation is when a claim is filed.

II. APPLICATION PROCESS

A. Application and Underwriting

When determining whom to insure, life, health, and disability insurers have the right to inquire about and learn what the applicant knows concerning the state of his or her health. The applicant for such coverage has a duty to provide, in good faith, all of the information asked for on the application and within his or her knowledge. This is so because the applicant’s health status is critical to an insurer’s ability to properly evaluate the risk it is being asked to insure, and the application for insurance is one of the most important tools provided to the insurer for risk assessment. Simply stated, requiring complete medical information and honesty on the part of applicants is necessary to control costs and avoid fraud.

Individual and small group insurance is not guaranteed and almost always is underwritten. In other words, applicants must qualify for coverage based on their medical and health history. This means that insurers employ a process to review and evaluate an individual’s risks and classify them according to their degrees of insurability. Appropriate rates then may

19. Hailey v. Cal. Physicians’ Serv., 69 Cal. Rptr. 3d 789, 799 (Ct. App. 2008). “[An insurance company] has the unquestioned right to select those whom it will insure and to rely upon him who would be insured for such information as it desires on a basis for its determination
be assigned and losses spread over these risks in an economically feasible manner. The underwriting process ensures that each proposed insured receives an equitable, consistent evaluation and, if accepted, is charged an appropriate premium for the coverage offered. 20 “One of the basic principles of insurance is that each individual insured pays a premium [that is] proportionate to the amount of risk the company assumes for that person.” 21 Without such underwriting, most people who purchase insurance in the individual market would pay considerably more for their health insurance premium. 22

Virtually all insurers initiate this underwriting process by requiring an applicant to complete an application that is used to determine whether to accept coverage. Insurers ask applicants questions about their medical history, including physicians seen, prescriptions taken, and other similar information. The applicant then signs the application attesting to the accuracy and completeness of the application and acknowledges that false or incomplete information may disqualify the individual from coverage. 23 It is the applicant’s responsibility to be sure that all information is correct and complete. 24 The application is then forwarded to the insurer for evaluation. Each company utilizes its own medical underwriting guidelines so that disclosed or discovered medical conditions are evaluated in a consistent manner. 25 Some medical conditions may result in an automatic decline while others may require further investigation. This can result in the insurer


24. The duty is balanced by the specificity of the application questions. See infra notes 43–73 and accompanying text.

25. Hailey, 69 Cal. Rptr. 3d at 802; In re Tri-State Armored Servs., 2007 WL 1196558, at *11.
charging a higher premium, increasing the waiting time for coverage, or excluding the condition from coverage.26

Not all individual insurance products require the same degree of underwriting.27 Due to changing dynamics in the health insurance market, supplemental policies are more often considered substitutes if major medical or long-term disability coverage is either unavailable or too expensive. Supplemental health insurance products may expand medical coverage or fill specific shorter-term needs, often to complement basic health insurance coverage.28 This type of coverage, however, is not a form of comprehensive health insurance. Benefits under such policies may be limited or subject to a stated maximum benefit. This is important because an insurer’s ability and duty to investigate applications must be balanced with the type and amount of coverage sought as well as the time and money involved in doing so.29 Applicants who do not reveal any prior or present health problems inquired about on the application (a clean application) often are issued coverage without further investigation because the insurer relies on the applicant to make truthful and accurate responses so that an informed underwriting decision can be made.30 It is physically and economically impossible for an insurer to fully and completely investigate

26. Insurers endeavor to set their rates so that the total premiums they collect will be sufficient to fund the benefits promised under a particular block of policies. See KENNETH BLOCK, JR. & HAROLD D. SKIPPER, JR., LIFE & HEALTH INSURANCE 27 (13th ed. 2000).
28. Ticconi v. Blue Shield of Cal. Life & Health Ins. Co., 72 Cal. Rptr. 3d 888, 892 ( Ct. App. 2008). For example, Blue Shield of California offers such coverage as “temporary, 12 month coverage to individuals, such as college students or those changing jobs, who need insurance while they are waiting for permanent coverage.” Id. More U.S. workers are losing their jobs and the group medical coverage that comes with employment. Enrollment Profits Slip at Insurer, WALL ST. J., Apr. 22, 2009, at B4; see also Health Plans Fast Losing Members to Layoffs, WALL ST. J., Apr. 23, 2009, at B3; Aetna Lowers 2009 Outlook, WALL ST. J., July 28, 2009, at B3. Overlaid on state requirements are the strictures of the federal Consolidated Omnibus Budget Reconciliation Act of 1985, 29 U.S.C. §§ 1161–67 (COBRA), which regulates the continuation of coverage for employees of, among other things, self-funded ERISA employee benefit plans. Under COBRA, an employee has the option to elect continuation of health coverage during a period that begins when he would otherwise lose coverage under his employer’s group health plan. Id. §§ 1161, 1166. COBRA requires the plan sponsor of each group health plan to provide each qualified beneficiary, who would lose coverage under the plan as a result of a qualifying event, an option to continue coverage under the plan. Id. § 1161. See also Fenner v. Favorite Band Int’l Inc., 25 F. Supp. 2d 870, 873 (N.D. Ill. 1998). The maximum coverage period is eighteen months. Id.
29. Some insurance applicants seeking large amounts of life, medical, or disability coverage may be required to gather extensive medical, personal, and/or financial information before approval. Other applicants, such as those applying for low amounts of coverage, may be approved based solely on the information contained in the application. Stewart v. Gulf Guar. Life Ins. Co., 846 So. 2d 192, 194 (Miss. 2002).
every potential insured to try and discover the less obvious defects in his or her health.\(^\text{31}\)

It is not uncommon for supplemental, short-term health and credit life and disability insurance to be issued based solely on health applications that ask specific questions. To qualify for these types of coverage, an applicant must be able to truthfully answer no to each of the medical questions on the application. An applicant who can truthfully answer no to every question immediately qualifies medically for coverage.\(^\text{32}\) Conversely, if the applicant answers yes to any of the medical questions, the applicant does not qualify for coverage. There is no discretion.\(^\text{33}\) Often, there is no place on the application to “explain” a yes response or list the identity of a treating physician and no variation in premium rates if the applicant has certain medical conditions. The policy is, in effect, wholly underwritten through the questions on the application, and no further health investigation is undertaken.\(^\text{34}\) These types of insurance are sold on the assumption that the applicant is truthfully disclosing all information requested on the application.\(^\text{35}\)

The applicant may, regardless of the type of coverage sought, make a misrepresentation in the application; and relying thereon, the insurer issues a policy. The false information, whether innocently or intentionally provided, often is only discovered during an investigation after a claim is submitted. The insurer may then seek to rescind the policy in accordance with applicable state law if it determines that it would not have issued coverage, would have limited the type of coverage issued, or would have charged more had the application fully and accurately disclosed all of the material facts.

### B. Elements Required for Rescinding Coverage

Rescission is an important tool for insurers to protect against misrepresentations by insureds because such conduct drives up costs. It is a basic principle of contract law that if one party to a contract has been led to enter into the agreement by the misrepresentation of the other party, the contract is voidable at the option of the innocent party.\(^\text{36}\) Public policy

---

33. Merrill, 978 So. 2d at 623.
requires that an insurer be permitted to rescind a policy if the insured seriously breached a duty of disclosure owed to the insurer. Accordingly, rescission is available to an insurer when an insurance policy was obtained due to incorrect information communicated by the insured that was material to the formation of the contract. In other words, a contract was never formed, and the parties are restored to the position they were in before the contract.

Reasons for revocation vary. Most of the time, these decisions involve disputes over what the policyholder disclosed or did not disclose on the insurance application. There are a variety of standards through a combination of statutory law and case law that have been developed by the states over the years to determine whether an insurer can properly rescind a life, health, or disability insurance policy. The three factors most widely

37. Kloutas v. Life Ins. Co. of Va., 35 F. Supp. 2d 616, 623 (N.D. Ill. 1998). Strong public policy against the proliferation of insurance fraud justifies an insurer’s right to rescind based on material misrepresentations contained in the application. Palisades Safety & Ins. Ass’n v. Bastien, 814 A.2d 619, 622 (N.J. 2003). “The risk that a policy might be rescinded as the result of misrepresentation or concealment clearly operates as a brake on any temptation by the insured to misrepresent or conceal facts from an insurer in order to obtain coverage. . . . The law of rescission is a major enforcement tool in maintaining the integrity of the insurance marketplace.” Joseph K. Powers, Pulling the Plug on Fidelity, Crime and All Risk Coverage: The Availability of Rescission as a Remedy or Defense, 32 Tort & Ins. L.J. 905, 907 (1987). This is true unless, of course, the insurer either has independent information or is otherwise placed on notice that a misrepresentation has been made prior to issuing coverage. Verex Assurance, Inc. v. John Hanson Sav. & Loan, 816 F.2d 1296, 1302–03 (9th Cir. 1987); Story v. Safeco Life Ins. Co., 40 P.3d 1112, 1117 (Or. Ct. App. 2002). See infra note 129 for a discussion regarding the insurer’s obligation to investigate.


used and appearing in varying combinations are as follows: (1) Was the misrepresentation false, fraudulent, or made with a total disregard by the applicant concerning its truthfulness? 40 (2) Was the misrepresentation material to the risk to be assumed by the insurer? Stated differently, would the insurer have refused to assume the risk or issued coverage under different terms had all the facts been disclosed? 41 (3) Did the particular insurer reasonably rely on the representations made by the applicant? 42

misrepresentation between the insurer and insured. During the contestable time period, the insured bears the risk. If the insurer discovers the concealment during this period, it may contest the policy’s validity. After that, the risk shifts to the insurer. Lin v. Metro. Life Ins. Co., No. 1:07-cv-03218-RJH, 2009 WL 806572, at *2 (S.D.N.Y. Mar. 30, 2009). See First Penn Pac. Life Ins. Co. v. Evans, No. AMD-05–444, 2007 WL 1810707 (D. Md. June 21, 2007), aff’d, No. 07–2020, 2009 WL 49734 (4th Cir. 2009) (rescission barred because insurer did not take appropriate steps to rescind within the two-year contestable time period). As stated by the California Supreme Court, an incontestability clause “does not condone fraud but merely establishes a time limit within which it must be raised.” Amex Life Assurance Co. v. Superior Court, 930 P.2d 1264, 1267 (Cal. 1997). A few states permit a challenge even after two years as long as the insurer can establish actual fraud on the insured’s part. Koch, 2009 WL 3346677, at *2. This means that the insurer must prove that the insured knowingly made untrue representations with the intent to deceive the insurer. Id. at *6. California now prohibits individual health insurers from rescinding coverage after the two-year contestability period expires even if actual fraud by the plan participant can be proven. Cal. Ins. Code § 10384.17 (2010). See Galanty v. Paul Revere Life Ins. Co., 1 P.3d 658, 665–67 (Cal. 2000), for a general discussion regarding the history of such provisions.


41. Courts have defined materiality as facts regarding an individual’s health or medical condition that are not truthfully stated or that have been withheld in response to application questions, where knowledge of the truth by the insurer would naturally influence its judgment in making the contract, estimating the risk, or fixing the premium. E.g., Garcia, 2009 WL 2905372, at *3. Materiality of a fact is established from the perspective of the insurer. Chen v. Vigilant Ins. Co., 2009 WL 2341444, at *4 (N.J. Super. Ct. App. Div. July 31, 2009). Asking specific questions (e.g., diagnosis or hospitalization for specified diseases) can be considered material as a matter of law, e.g., “in a life insurance policy application, wherein the applicant’s history of serious heart problems is a common-sense deal breaker for coverage.” Caribbean I Owners’ Ass’n, Inc. v. Great Am. Ins. Co., 600 F. Supp. 2d 1228, 1243 n.18 (S.D. Ala. 2009). The best way to establish materiality is through not only the testimony of an underwriter but also production of the company’s underwriting manual or guidelines indicating that the medical condition at issue would require the insurer, if known, to take different action, along with the application asking for information about the specific medical condition in question. Lin, 2009 WL 806572, at *5.

Insurers that rely exclusively on the application to determine eligibility for coverage should ask questions directed to obtain all necessary information to make an informed underwriting decision. Otherwise, relying solely on an application may result in insuring individuals having higher mortality or morbidity rates than those that would have been insured only after more extensive medical underwriting.43

1. Objective Questions

Objective questions offer the most protection to an insurer. These questions require information within the applicant’s knowledge, such as advise or treatment by a doctor, medications prescribed, or various medical conditions considered to be important by the insurer.44 They are considered to be objective because their accuracy may be proven by direct evidence.45

Unlike subjective questions, the insurer is not requesting a response only if the applicant believes the medical condition(s) for which he or she is receiving treatment is important or significant; any such condition inquired about on the application must be disclosed. The insurer, not the applicant, determines the significance of any such medical issue.46

43. Hailey, 69 Cal. Rptr. 3d at 799 (“The [Application] . . . is no model of clarity and lends credence to [the plaintiff’s] explanation of . . . health information.” Nieto v. Blue Shield of Cal. Life & Health Ins. Co., 103 Cal. Rptr. 3d 906, 911 (Ct. App. 2010). Likewise, the insurer must rescind coverage within the policy’s contestable time period. “The [insurer] issued the life insurance policy based upon the representations in the application for coverage, and the burden rested on it to investigate, within the two-year contestability period, the veracity of the representations [made by the insured] . . . which were ascertainable by the [insurer] at the time the policy was issued, and which it is precluded from contesting more than two years thereafter.” Yasch v. Bankers Life Ins. Co. of N.Y., 847 N.Y.S.2d 595, 596–97 (App. Div. 2008). This limitation constitutes a compromise between the insurer’s ability to contest a policy’s validity and the insured’s interest in preventing challenges over the policy’s validity many years after the policy was issued and premiums were paid. Irvine v. Reliance Standard Life Ins. Co., No. 08-CV-0411, 2009 WL 2231681, at *3 (D. Minn. July 24, 2009). See supra note 39.


46. Lin, 2009 WL 806572, at *9 (“Mr. Lin’s beliefs about his present medical condition . . . did not excuse his failure to disclose his treatment history, a fact that, as the record shows, had independent significance to [the insurer].”); Henriques v. N.J. Mfg. Ins. Co., No. L-2048–06,
2. Subjective Questions

In other applications utilized by some insurers, the applicant is requested to only answer questions that call for statements that are actually matters of opinion or judgment; these applications seek the subjective belief of the applicant as to whether past occurrences may give rise to future claims. For example, applicants are asked whether they are in “good health” or “free from any physical or mental disorder.” These types of application questions, if taken literally, would require the disclosure of even the slightest medical condition ever suffered by the applicant. Courts have interpreted such questions to mean that the insurer is only interested in serious medical conditions as understood from a layman’s point of view and understanding, not a medical opinion. Courts provide more deference to the insured when reviewing any alleged misrepresentation in such cases because the question only inquires about the insured’s knowledge and belief. With respect to subjective questions, “an insurer must demonstrate not only that an answer [is] false, but also that the insured knew that it was false.”

This issue was addressed in Williams v. Union Fidelity Life Insurance Co. Here, Mr. & Mrs. Williams purchased a new pickup truck along with credit life insurance. Mr. Williams signed a health application to obtain this coverage, stating thus:

I hereby certify that I am in good health and am not under treatment for, or receiving medical advice for any illness, disease, or physical or mental

---


48. Wade v. Olinger Life Ins. Co., 560 P.2d 446, 448, 450 (Colo. 1977); Henriquez, 2009 WL 5125021, at *5 (“Courts are more lenient toward an insured when reviewing misrepresentations in response to a subjective question, because such a response could be said to be a correct statement of the insured’s knowledge and belief.”).


52. 123 P.3d 213 (Mont. 2005).

53. Id. at 216.
impairment. In addition, I have not been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Relating Complex, or tested positive for Antibodies to the AIDS virus.\textsuperscript{54}

Once an individual signs this application, insurance is issued immediately. There was no space to include any medical information nor a request for doctor names or a release for medical information.\textsuperscript{55}

Nine months later, Mr. Williams died, and the death certificate stated that death resulted from “renal cell carcinoma with metastasis,” which had “existed for years.”\textsuperscript{56} The insurer only then investigated Mr. Williams’s health history, and based on medical information received confirming this long-standing illness, coverage was rescinded for material misrepresentation.\textsuperscript{57}

The Montana Supreme Court noted, in reversing a jury verdict for the insurer, that this application sought information only to the best of the applicant’s knowledge and belief as to his health. No facts were required to be disclosed.\textsuperscript{58} Montana law uses a subjective standard for evaluating an applicant’s certification as to his good health.\textsuperscript{59} As long as it appears that the insured had reason to believe and did believe that at the time of his application he was in good health, even though it subsequently develops that his health was not good, a recovery should be awarded because his statement was only to the extent of his knowledge and belief.\textsuperscript{60} In other words, a jury must decide “what [the insured] knew and what he believed.”\textsuperscript{61}

Likewise, in \textit{Southern United Life Insurance Co. v. Caves},\textsuperscript{62} the complete absence of underwriting standards pertaining to an applicant’s medical history was held against an insurer. The case concerned an application for credit life insurance made in conjunction with an automobile loan.\textsuperscript{63} The only standard used by the insurer for approving an application provided that the insured must be in “insurable health.”\textsuperscript{64} The insurer did not utilize a written application requesting health information and did not provide the agent with any standards for determining an applicant’s eligibility.\textsuperscript{65} The insurer’s standard procedure for determining eligibility concerned reviewing an applicant’s character and mode of living and did not include an

\begin{footnotes}
\item[54.] Id.
\item[55.] Id. at 217.
\item[56.] Id.
\item[57.] Id.
\item[58.] Id.
\item[59.] Id. at 222.
\item[60.] Id.
\item[61.] Id.
\item[62.] 481 So. 2d 764 (Miss. 1985).
\item[63.] Id. at 765–66.
\item[64.] Id. at 766.
\item[65.] Id.
\end{footnotes}
investigation of the applicant’s medical condition. The applicant died of a heart attack shortly after obtaining coverage, and the insurer rescinded the policy on the ground that the applicant was not in insurable health at the time the policy was obtained.

The court held that the insurer was not justified in rescinding the policy. Insureds responding to such open-ended questions may interpret their meaning very differently than the insurer. These questions call for statements of opinion and will be accepted by the courts unless the insured had a medical condition that a reasonable person would understand as not being in good health.

Where an insurance company makes no effort to establish clear and meaningful guidelines to assist its agents in discerning persons eligible for coverage, but merely relies on the agents’ judgment to select those persons appearing to be healthy, that company by its actions manifests an intention to “insure the world.” An insurer can protect itself from insuring bad risks by asking objective questions.

Not all courts, however, take such a liberal approach, even when an insurer relies only on subjective questions to support a rescission. For example, in Skinner v. Aetna Life Insurance Co., the court rejected the insured’s contention that he believed he was in good health. “If accepted, then any statement made by the insured based on his knowledge and belief could never be false as a matter of law. To conclude otherwise would be to place insurance companies at the mercy of those capable of the most invincible self-deception.”

III. POST-CLAIM UNDERWRITING AS EVIDENCE OF BAD FAITH

A. Plaintiff’s Position

Claimant attorneys and some regulators argue that the medical underwriting of individual and small group health insurance is often abused by relying

66. Id. at 768.
67. Id. at 766.
68. Id. at 768.
69. Id. at 766.
70. Id. at 768.
72. 804 F.2d 148 (D.C. Cir. 1986).
73. Id. at 151; see also Consumer First Ins. Co. v. Lee, 2009 WL 425948, at *4 (N.J. Super. Ct. App. Div. Feb. 24, 2009) ("Even where a subjective standard is employed, however, the responses given by an insured must accord with external realities. In other words, the subjective intent of the insured ‘may not be controlling when the undisputed facts reveal otherwise.’") (citation omitted).
solely on application responses. They contend that insurance applications too often seek health history information that is confusing, overbroad, and ambiguous, preventing insureds from fully understanding the meaning of the questions or the consequences of their answers to the questions. The insurance policy is then issued without the insurer even contacting the insured to verify the accuracy of the application responses or checking the medical records of physicians if they are listed in the application.

Plaintiff attorneys argue that many insurers know that should a large claim be filed during the contestable period, the coverage can then be underwritten more carefully and, if possible, rescinded. In other words, plaintiff attorneys argue that these companies simply lie in wait, collecting premiums and earning interest until an insured becomes seriously ill. Only then does the insurer spend the necessary time and expense to extensively scrutinize medical records looking for some information that had not been disclosed on the application. This practice, disparagingly referred to by these attorneys as post-claim underwriting (also sometimes called retroactive underwriting), is unfair because it allows an insurer to accept income generated from these policies while knowing that it may at a later date challenge the application and avoid liability. This makes the issuance of a policy almost meaningless from the point of confirming that coverage is effectively in force.

74. Blue Cross of Cal., Inc. v. Superior Court, 102 Cal. Rptr. 3d 615, 621, 632 n.13 (Ct. App. 2009); Hailey v. Cal. Physicians’ Serv., 69 Cal. Rptr. 3d 789, 799 (Ct. App. 2008); Clark v. Old Mut. Fin. Network, No. 07 CV 4895, 2009 WL 2589499, at *4 (N.D. Ill. Aug. 19, 2009); see Prudential Ins. Co. of Am. v. Dukoff, 2009 WL 4884008, at *6 (E.D.N.Y. 2009) (“The Court in its own anecdotal experience has noticed that, all too often, insurance policies contain language that is confusing not only to consumers, but even to experienced attorneys.”); see also Shokrian, 2009 WL 2488881, at *6 (“[L]ay persons lack ‘the level of knowledge or understanding’ possessed by doctors or other experts; [i]t would be ‘patently unfair’ to allow the insurer to avoid its objections under the policy on the basis of information [the insured] did not know, or alternatively, did not fully understand.”) (citations omitted).


78. White, 831 F. Supp. at 1556; Lewis, 637 So. 2d at 188.


80. Insurers utilizing post-claim underwriting provide insureds with the feeling that they were issued “bogus” policies; the insurer will engage in this post hoc evaluation only after the claim is submitted “for the purpose of ridding themselves of the insureds.” Provident Indem. Life Ins. Co. v. James, 506 S.E.2d 892, 894 (Ga. Ct. App. 1999).
Insurers, according to these critics, should be precluded from denying benefits to the insured or beneficiary on the basis of information that could have been obtained through a careful investigation prior to the issuance of coverage. It is unfair for an insured to purchase an insurance policy and pay premiums only to have coverage rescinded when a claim is submitted based on information available to the insurer at the time of application.81 This conduct indicates that the insurer did not reasonably rely on the application and should now be barred from rescinding coverage.82 By covertly reserving the right to rescind coverage whenever they want, insurers eliminate a significant risk from their business.

Accordingly, some courts have adopted the plaintiffs’ arguments and held that good underwriting practice requires the insurer to perform all necessary underwriting at the time that an application is received and to investigate thoroughly the policyholder’s medical history before, not after, issuing coverage.83 The application should be denied immediately if an insured is not an acceptable risk. Misrepresentations contained in the application are excused because the insurer was fully capable of obtaining whatever facts it needed before deciding to issue coverage, and the burden of performing such an investigation should fall upon the insurer.84 This is especially important because of the consequences an insured will suffer when coverage is rescinded. In addition to preventing the policyholder from recovering on the claim at issue and sometimes leaving him with extremely large medical bills, the insured may later be prevented from obtaining other coverage for a specific condition or, for that matter, any coverage at all.85

B. Insurer’s Duty of Good Faith

The law implies a covenant of good faith and fair dealing in every contract.86 This is especially true in insurance contracts because the law imposes special duties “of a fiduciary nature” on the insurer.87 These duties

include equal consideration, fairness, and honesty. These principles are especially important in the context of claim handling. An insurer while adjusting a claim must, among other things, treat the insured or beneficiary fairly and treat the insured’s interests at least equal to its own interest. This means that an insurer must, before it denies or rescinds coverage, conduct a full, complete, and objective investigation that includes searching for and not disregarding facts that would support the insured’s claim for benefits.

Plaintiffs contend that insurers breach this covenant when instead of looking to pay the claim, their investigation is merely a pretext to permit the policy to be rescinded. An insurer’s investigation violates industry standards when it conducts a negative investigation. This means that the insurer looks for facts to avoid liability instead of searching for reasons to pay. This, according to claimant attorneys, is exactly the type of conduct engaged in when insurers use post-claim underwriting.

C. Cases Supporting Illegality

Some cases have held that a failure to adequately underwrite a policy at the time of its sale will preclude the insurer from rescinding coverage based upon the post-claim discovery of material misrepresentations or omissions.

The Mississippi Supreme Court applied such an analysis in Reserve Life Insurance Co. v. McGee, which concerned a medical/hospitalization policy. Here, the insurance agent did not review the individual questions of the policy application with the applicant (who had a third-grade education) but rather completed the questions based upon the applicant’s assurances that his health was good. The applicant granted the insurer written authority to obtain his medical records and contact his physician. However, the insurer failed to obtain these records until the policyholder filed a claim. At that time, the insurer determined that the policyholder had a history of transient ischemic attacks (ministrokes) and rescinded the policy based upon the policyholder’s duty to disclose. The trial court held that the

90. Id.
92. 444 So. 2d 803 (Miss. 1983).
93. Id. at 804.
94. Id. at 805–06.
95. Id.
insurer “was guilty of gross negligence, manifest bad faith and abuse of the plaintiff.” The court observed that allowing the insurer “to ‘sandbag’ and gloss over its investigation of plaintiff’s medical history at the time of evaluating the underwriting risk then comb his prior record intensively for five months ‘looking for a defense’ . . . is to invite manifest abuse of the public in such relationships.” The Mississippi Supreme Court upheld a punitive damages award in favor of the insured based on the health insurer’s bad faith in conducting what is now referred to as post-claim underwriting.

The most cited case challenging the practice of post-claim underwriting is *Lewis v. Equity National Life Insurance Co.* Here, the Mississippi Supreme Court developed the term *post-claim underwriting* and held that a health insurer may not deny a claim based on information about the insured’s health that the insurer could easily have obtained before issuing the policy.

On April 12, 1989, Florence Lewis purchased an individual intensive care policy that provided a $200 per day benefit. Her monthly premium was $3. She answered “no” to the application question: “Has any person proposed for intensive care or heart attack insurance ever been diagnosed or treated as a victim of heart attack, heart condition, heart trouble or any abnormality of the heart?” She was subsequently injured in an automobile accident, spending one night in a hospital intensive-care unit (ICU). When filing her claim, Lewis completed a claimant’s statement that contained a doctor’s statement indicating heart treatment for a coronary occlusion in 1983. The underwriting department rescinded coverage when it learned that Lewis had a preexisting heart condition. No further investigation was undertaken by the insurer.

Lewis sued, alleging a number of legal theories, including the insurer’s failure to timely investigate her health history. The insurer obtained sum-
mary judgment insofar as it related to Lewis’s claim for punitive damages.\textsuperscript{108} A trial was then held, and a jury awarded Lewis $200 for her one-day ICU confinement.\textsuperscript{109} Lewis appealed, arguing in part that Equity National engaged in illegal underwriting practices by waiting until the claim had been filed to obtain information and making underwriting decisions that should have been made when the application was made, not after the policy was issued.\textsuperscript{110} The Mississippi Supreme Court agreed and reversed the trial court’s partial summary judgment order, remanding the case for trial on these issues.\textsuperscript{111}

The court heavily criticized the insurer’s practice of post-claim underwriting. The insurer controls when the underwriting occurs.\textsuperscript{112} It therefore should be estopped from determining whether to accept an insured six months or more after a policy is issued. If the insured is not an acceptable risk, the application should be denied up front, not after a policy is issued.\textsuperscript{113} The court observed that “[a]n insurer has an obligation to its insureds to do its underwriting at the time the policy application is made, not after a claim is filed.”\textsuperscript{114} This allows the proposed insured an opportunity to seek other coverage with another company because no company will insure an individual who already has suffered a serious illness or injury.\textsuperscript{115}

\text{[I]t is patently unfair for a claimant to obtain a policy, pay his premiums and operate under the assumption that he is insured under a specific risk, only to learn after he submits a claim that he is not insured, and, therefore, cannot obtain any other policy to cover the loss.}\textsuperscript{116}

Based upon evidence that no underwriting was done on plaintiff’s policy until after the claim was filed, the court held that the allegations of post-claim underwriting supported an award of punitive damages.\textsuperscript{117}

Significantly, the court, acknowledging that small policies with low premiums such as the one sold to Lewis are issued under simplified guidelines, still ruled that the insurer must bear the burden and expense of investigating

\textsuperscript{108} Id. at 186.
\textsuperscript{109} Id.
\textsuperscript{110} Id. at 188–89.
\textsuperscript{111} Id. at 186.
\textsuperscript{112} Id. at 188–89.
\textsuperscript{113} Id.
\textsuperscript{114} Id.
\textsuperscript{115} Id.
\textsuperscript{116} Id.
\textsuperscript{117} Id. at 189–90. The Mississippi Supreme Court later affirmed its attack on post-claim underwriting. Am. Income Life Ins. Co. v. Hollins, 830 So. 2d 1230, 1236 (Miss. 2002) (“We have condemned this practice of post-claim underwriting in \textit{Lewis} and cautioned insurers to abstain from such practices in the future.”).
medical histories of its insureds prior to issuing policies. In other words, the risk of the insured’s dishonesty is placed upon the insurer.\footnote{Lewis, 637 So. 2d at 189; see also Ticconi v. Blue Shield of Cal. Life & Health Ins. Co., 72 Cal. Rptr. 3d 888, 896 (Ct. App. 2008).} Plaintiffs continue to assert in Mississippi that post-claim underwriting is illegal. See, e.g., First Colony Life Ins. Co. v. Sanford, 555 F.3d 177 (5th Cir. 2009); accord Hage v. UnumProvident Corp., No. 04–5933 (MLC), 2008 WL 5423954, at *4 (D.N.J. Dec. 29, 2008).

It appears, however, that several Mississippi decisions place into question whether Lewis is still good law as it relates to the illegality of post-claim underwriting. In Gordon v. National States Insurance Co., 851 So. 2d 363 (Miss. 2003), the insured applied for two $6,000 life insurance policies, signing the application in which he denied, among other things, that within the past two years he had received medical treatment for heart failure. The application stated that if the applicant responds in the affirmative, he is not eligible for coverage. Id. at 364. Based solely on the representations contained in the application, the insurer issued coverage. The insured died approximately six months later and only then did the insurer conduct an eligibility investigation by obtaining medical records. These records indicated that the insured had, in fact, been under treatment for congestive heart failure. Coverage was rescinded. The widow contended that the agent knew about her husband’s medical problem. The agent denied any such knowledge, but the insurer decided to pay the claim anyway. The widow still sued for bad faith. The trial court granted summary judgment for the insurer, and the Mississippi Supreme Court affirmed. The court said that “National’s initial denial of payment was justifiably based.” Id. at 365. Only after the allegation of agent knowledge was alleged did the insurer reconsider. The court also said that “[n]o evidence has been presented to suggest that National acted with malice, gross negligence or reckless disregard in handling . . . [the] claim.” Id. at 366. The issue of the insurer’s post-claim underwriting was not mentioned.

Likewise, in Bullock v. Life Insurance Co. of Mississippi, 872 So. 2d 658 (Miss. 2004), the Mississippi Supreme Court upheld the insurer’s right to rescind coverage based solely on the insurer’s post-claim investigation. Here, the insured signed an application for credit life and disability insurance to protect a loan. Id. at 659. She represented that she was not disabled and was actively engaged in full-time employment. The insurer issued coverage without any preissue investigation. The insured later sought benefits, alleging that she fell and injured her foot and hand. Id. at 660. The insurer only then learned that plaintiff owned coverage with several other insurance companies and had filed claims for disability benefits alleging losses that predated her application with defendant. Id. at 661. The trial court granted the insurer’s summary judgment motion, permitting it to rescind coverage for material misrepresentation. The Mississippi Supreme Court affirmed. Id.

Finally, in United American Insurance Co. v. Merrill, 978 So. 2d 613 (Miss. 2007), Robert Merrill purchased a life insurance policy paying $5,000 to cover his burial expenses; he died eight months later from a heart attack caused by high blood pressure. Id. at 621–22. The subsequent claim was denied and coverage rescinded because after a post-claim contestability investigation, the insurer determined that Merrill failed to disclose on his application that he had been treated for congestive heart failure within the three-year time period preceding his application for coverage. Id. at 622–23. The insured’s treating physicians denied that he ever suffered from this condition nor were there any medical records to support the insurer’s underwriting department’s conclusions. Id. at 623. Yet, the insurer upheld its decision to deny benefits. Id. Accordingly, the Mississippi Supreme Court affirmed a compensatory and punitive damages award. Id. at 631. However, at no time was the issue of the legality of the insurer’s post-claim underwriting raised. Id. at 622. In fact, the Mississippi Supreme Court actually cited Lewis but only for the issue of awarding punitive damages. Id. at 635.

The facts in each of the above three cases are strikingly similar to those in Lewis: a small policy with no preissue investigation regarding the accuracy of the application. The facts in Gordon, Bullock, and Merrill clearly fell squarely within the definition of post-claim underwriting, yet the Mississippi Supreme Court did not mention, much less discuss, the Lewis or Holins decisions regarding the illegality of this practice.
Post-Claim Underwriting

The Alabama Supreme Court in *Huff v. United Insurance Co.*119 also seriously questioned (but did not invalidate) an insurer’s ability to engage in post-claim underwriting. The insurer’s sales agent sold a life insurance policy to John Huff. No health problems were disclosed on the application.120 Huff, however, had been treated for heart problems; and soon after the policy was issued, he died of a heart attack.121 The insurer only then investigated his health history and uncovered his medical problem. The policy was rescinded because Huff materially misrepresented his health on the application.122 The widow sued, and the trial court granted the insurer partial summary judgment on all claims alleging fraud.123 The Alabama Supreme Court affirmed, but also said thus:

This fact situation illustrated an all-too-common situation for Alabamians in life insurance transactions. United issued the policy without investigating the applicant’s health. As the law in Alabama currently stands, an insurance company may issue a life insurance policy with its knowledge of its applicant’s health coming solely from its agent’s questioning of the applicant about his or her health history. The benefits from this type of transaction lie solely in favor of the insurance company and its agent. The insurance company receives premiums month after month, while the agent retains a commission from the sale. But when the insured dies, the insurance company refuses to pay the benefits provided by the policy. Its refusal is based on its discovery, for the first time, that the insured’s health was poor. When the policy is sold, an agent is not required to delve thoroughly into the applicant’s background for the details of his health history. Such a requirement could prevent situations like the one in this case.124

IV. POST-CLAIM UNDERWRITING
(INVESTIGATION) IS LEGAL

A. Insurers’ Position

Rescission of coverage is rarely used but is necessary to ensure that people who lie about their medical condition do not taint the risk pool for honest

---

119. 674 So. 2d 21 (Ala. 1995).
120. *Id.* at 22.
121. *Id.*
122. *Id.* at 22–23.
123. *Id.* at 23.
124. *Id.* Recent decisions applying Alabama law have not adopted this approach. The U.S. Court of Appeals for the Eleventh Circuit affirmed the right of an insurer to rely on an applicant’s responses to application questions. *Mega Life & Health Ins. Co. v. Pieniozek*, 516 F.3d 985, 989 (11th Cir. 2008) (permitting an insurer to rescind a life insurance policy based on “its routine investigation” after the insured died within the contestable time period, and noting that “an insurance company does not normally have a duty to inquire further to verify that an applicant has told the truth”) (Alabama law) (citation omitted); *see also* *Caribbean I Owners’ Ass’n v. Great Am. Ins. Co. of N.Y.*, 600 F. Supp. 2d 1228, 1240 (S.D. Ala. 2009) (supporting an insurer’s right to rely on the insured’s representations in the application under Alabama law).
consumers. The risk that a policy might be rescinded as the result of misrepresentation or concealment clearly operates as a brake on any temptation by the insurer to misrepresent or conceal facts from an insurer in order to obtain coverage at a lower premium or on terms that would not be offered if the true facts were disclosed. The law of rescission is “a major enforcement tool in maintaining the integrity and commercial dynamics of the insurance marketplace.”

This is especially true today because some people, especially those with health problems, anxious over being caught uninsured or paying extremely high premiums, are going to great lengths to obtain or keep health coverage. If people who are unhealthy obtain insurance at the preferred premiums given to healthy people, premiums for everyone else are increased. Insurers contend that their underwriting is based on the information provided by the insured. Often, the insurance application discloses nothing about the applicant's medical condition or history, and there are no issues to be addressed prior to issuing the coverage for which the applicant applied. Insurers contend that in such an instance, they should not be required to undertake the time-consuming and expensive investigation of each applicant's medical history to determine if there are material misrepresentations contained in the application, which often includes interviewing the applicant and consulting with the applicant’s physicians.

125. Joseph K. Powers, Pulling the Plug on Fidelity, Crime and All Risk Coverage: The Availability of Rescission as a Remedy or Defense, 32 Tort & Ins. L.J. 905, 907 (Summer 1997); see also In re Tri-State Armored Servs., No. 06–226, 2007 WL 1196558, at *12 (D.N.J. Apr. 23, 2007). The National Association of Insurance Commissioners (NAIC) on December 3, 2009, issued a report on rescissions in the Individual Health Insurance Market. NAIC Regulatory Framework (B) Task Force, NAIC Rescission Data Call (draft) (Dec. 17, 2009), available at www.naic.org/documents/committees_b_regulatory_framework_rescission_data_call_report.pdf. NAIC found that the rate of rescissions was 3.7 policies rescinded per 1,000 written over a five-year time period covering 2004 to 2008 for surveyed companies writing individual major medical policies or individually underwritten certificates. The data revealed that there were approximately 27,246 rescissions against a sampling size of about 6.7 million issued policies. See, e.g., Ticconi v. Blue Shield of Cal. Life & Health Ins. Co., 72 Cal. Rptr. 3d 888, 893 (Ct. App. 2008) (insurer reported that for 249,679 short-term health insurance policies issued between January 1, 2000, and June 30, 2005, it rescinded only 207 for misrepresentation).

the contrary, an applicant has the responsibility to disclose everything he or she knows about the conditions inquired about on the application, and the insurer is entitled to accept those responses in determining whether to issue coverage.\textsuperscript{128} There should be no duty nor is there the ability to investigate conditions that were inquired about but not disclosed on the application.\textsuperscript{129} Accordingly, should new information be obtained by the insurer during the claims process, the insurer has the right to investigate the insured’s actual medical history and to rescind coverage if appropriate.

\textbf{B. Insured’s Duty of Good Faith}

The arguments presented by policyholder attorneys ignore the traditional rules governing the first-party insurer/insured relationship. It has long


\textsuperscript{129} Silver v. Colo. Cas. Ins. Co., 219 P.3d 324, 331 (Colo. Ct. App. 2009) (“The general rule . . . adopted in the clear majority of jurisdictions, is that an insurer has a duty to investigate representations in an application only if it has sufficient information that would put a reasonably prudent insurer on notice of a possible misrepresentation and would have caused the insurer to begin an inquiry.”); see also Golden, 551 A.2d at 1015; Wachel v. First Colony Life Ins. Co., No. 2:05-CV-292-PRC, 2008 WL 73647, at *18–19 (N.D. Ind. Jan. 4, 2008) (“[A]n insurer may rely on the representations of fact contained within an application for insurance that are attested to by the applicant and is not under a duty to look beyond the representations as they may appear on the application. . . . It is not unreasonable to demand that an insured supply accurate and complete information, read the application before signing it, and suffer the consequences if an omission or misstatement in the application is material to a subsequent loss.”). In fact, one court went so far as to say that the insurer need not even review its own internal files unless there is a circumstance that brings the false information to the insurer’s attention. Scottsdale Ins. Co. v. Wave Tech. Commc’ns, Inc., No. 08–17088, 2009 WL 2448259, at *2 (11th Cir. Aug. 12, 2009). When an applicant discloses a prior medical history on the application, the courts are more willing to place the burden on the insurer to further investigate the applicant’s health prior to issuing coverage. For example, an insured’s disclosure of high blood pressure on the application raised a question of fact about whether a reasonable insurer would have conducted an inquiry prior to issuing coverage. Brown v. Empire Fire & Marine Ins. Co., No. 3:07cv644 DPJ-JCS, 2009 WL 2242437, at *2 (S.D. Miss. July 24, 2009); Rowley v. USAA Life Ins. Co. 670 F. Supp. 2d 1199, 1206 (W.D. Wash. 2009) (insured’s disclosure of treatment for back and neck pain as well as migraines along with medication raised triable issues of fact).
been the law that both parties to an insurance contract owe each other a duty of good faith and fair dealing.\textsuperscript{130} This duty to exercise good faith includes the applicant’s responsibility to complete truthfully the insurance application seeking information concerning an applicant’s medical and social conditions.\textsuperscript{131} The first-party insurer is not a fiduciary and owes no obligation to consider the interests of its insured above its own.\textsuperscript{132}


\textsuperscript{131} Casey \textit{ex rel.} Casey v. Old Line Life Ins. Co., 996 F. Supp. 939, 944 (N.D. Cal. 1998); Pope v. Mercury Indem. Co. of Ga., 677 S.E.2d 693, 698 (Ga. Ct. App. 2009). The implied promise requires each contracting party to refrain from doing anything to injure the right of the other to receive the benefits of the agreement. The exact nature and extent of the duty imposed by such an implied promise will depend on the contractual purposes. Egan v. Mut. of Omaha Ins. Co., 620 P.2d 141, 143 (Cal. 1979).


The relationship between the insurer and its insured in the first-party context is still contractual rather than fiduciary. The first-party insurer must not thwart in bad faith the insured’s reasonable expectations under the policy. Rawlings v. Apodaca, 726 P.2d 565, 571 (Ariz. 1986). This is a significantly lesser obligation than that owed by a fiduciary. Merchants & Planters Bank v. Williamson, 691 So. 2d 398, 404–05 (Miss. 1992). It only "requires abstinence by all parties from commission of wrongful conduct which injures the ‘right of [another] to receive the benefits of the agreement.’" Andrew Jackson Life Ins. Co. v. Williams, 566 So. 2d 1172, 1188 (Miss. 1990). The duty of good faith and fair dealing merely requires the parties to deal fairly with one another and does not require the high standard of trust present in a fiduciary relationship. Herrin v. Med. Protective Co., 89 S.W.3d 301, 308 (Tex. App. 2002). No fiduciary duty arises when an insurer sells a policy to an insured; the relationship is only commercial. Nw. Mut. Life Ins. Co. v. Gil, No. 3:07-cv-0030 (VLB), 2009 WL 276086, at *6 (D. Conn. Feb. 5, 2009).

The true fiduciary relationship exists in the third-party insurer-insured relationship, not the first-party relationship. Millwood v. State Farm Mut. Auto. Ins. Co., No. 08–1698, 2009 WL 291168, at *5 (W.D. Pa. Feb. 5, 2009). Third-party insurance coverage, such as liability for the operation of automobiles, homeowner’s, landlord-tenant, and general liability, offers a greater conflict and potential for bad faith conduct. Here, the insurer is obligated to pay sums that the insured is requested to pay to a third party in discharge of the insured’s own personal liability to that third party. The physical injury is that of a third party, not the insured. The insured’s potential liability exists independent of any insurance. Lockwood Int’l v.
Questions in an application seek to reveal material information. It is the insurer’s right, not the applicant’s, to determine what health issues and treatments received are relevant or inconsequential; to decide whether the applicant is an acceptable risk; and, if so, on what terms. This rule is premised on the fact that the proposed insured alone has complete knowledge of facts concerning his or her health, and the statements in the application are in many instances the determining factor that the insurer uses in deciding whether to issue a policy. Even if the insured does not agree with opinions provided by his or her doctors, the insured still has a duty to disclose his or her medical history, and the failure to do so constitutes grounds for recission. As the U.S. Supreme Court long ago stated in Stipcich v. Metropolitan Life Insurance Co., “[e]ven the most unsophisticated person must know that in answering the questionnaire and submitting it to the insurer, he is furnishing the data on the basis of which the company will decide whether, by issuing a policy, it wishes to insure him.”

An essential element of the insurer’s underwriting evaluation is trust. The law charges an insurance applicant with reasonableness. Underwriters presume that the information presented by the applicant is true. This traditional view allows an insurer to rely upon the information contained in an insured’s application for insurance and provides that it does not have to
verify independently the accuracy of reported information.\textsuperscript{139} Accordingly, when an applicant for life, health, or disability insurance is asked on an application for material information\textsuperscript{140} about his or her health or medical history and the specific information requested is not provided or answered untruthfully, the insurer is entitled to rescind the policy.\textsuperscript{141}

C. Cases Supporting Post-Claim Underwriting

A number of courts have recognized the right of insurers to investigate suspicions of material misrepresentations or omissions even after a claim has been filed. These decisions emphasize the insurer’s right to rescind life, health, or disability policies for material misrepresentations or omissions on applications relating to the policyholder’s medical history or current health status. In fact, several courts have actually rejected the Mississippi

\textsuperscript{139} In re Tri-State Armored Servs., Inc., 332 B.R. 690, 716–17 (D.N.J. 2005); Smith v. AF&L Ins. Co., 147 S.W. 3d 767, 777 (Mo. Ct. App. 2004). As stated in American General Life Insurance Co. v. Green, No. 2:06-CV-02048-MCE-KJM, 2008 WL 2096833, at *8 (E.D. Cal. May 16, 2008), “the case law actually seems to indicate that it is standard procedure to conduct a contestability investigation if the insured dies during the period in which the policy is still contestable.” Likewise, in Yang v. Peoples Benefit Insurance Co., No. CIV F 06–455, AWI DLB, 2007 WL 1555749, at *2 (E.D. Cal. May 25, 2007), the court stated, “[The insured’s] death occurred within the Policy’s two-year contestable time period, [the insurer] conducted a standard contestable investigation which included obtaining and reviewing [the insured’s] medical records and obtaining an underwriting review of the medical records that existed prior to the date of the application. Investigations during the contestability period verify or determine whether the representations made on the application are accurate. The purpose of the investigation was to determine whether the policy would have been issued as applied for if [the insured] had fully disclosed her medical history on her application.” See also Caribbean I Owners’ Ass’n v. Great Am. Ins. Co. of N.Y., 600 F. Supp. 2d 1228, 1240 (S.D. Ala. 2009) (noting an insurer’s ability to rescind “does not hinge on the adequacy or existence of the insurer’s own investigation; to the contrary, the mere fact ‘[t]hat the insurer could make its own investigation does not lessen its right to rely on the representations on the application’” (citation omitted)).

\textsuperscript{140} See supra note 41 for a discussion of what information is considered to be material.

\textsuperscript{141} New Eng. Life Ins. Co. v. Signorello, 119 F. Supp. 2d 1052, 1059 (N.D. Cal. 2000); W. Coast Life Ins. Co. v. Ward, 132 Cal. App. 4th 181, 187 (2005). As stated in Morgan v. Household Life Insurance Co.: “It is undisputed that no one from [the insurance company] did an independent investigation into whether the answers provided by the [insureds] were true. . . . Plaintiff argues that [the insurer’s] process is ineffective at obtaining accurate information, and therefore, that [the insurer] did not use reasonable care in relying on the [insureds’] misrepresentations. However, ‘[w]hen answers to an application are complete on their face, the insurer is not obligated to make further inquiry.’ . . . The cases cited by Plaintiff establishing a duty to investigate are distinguishable because in those cases there was information in the application that should have put the insurer on notice that other information provided was false. . . . Here, there was nothing in the application that should have alerted [the insurer] that the [insureds] had misrepresented Mr. Morgan’s health history.” No. 08–0462-CV-W-OD, 2009 WL 1259969, at *5–6 (W.D. Mo. May 5, 2009) (citations omitted); see also United Auto. Ins. Co. v. Salgado, 22 So. 3d 594, 601 (Fla. Dist. Ct. App. 2009) (“[I]t is well established law that ‘an insurance company has the right to rely on an applicant’s representations in an application for insurance and is under no duty to further investigate.’”).
Supreme Court’s decisions that post-claim underwriting is illegal\textsuperscript{142} and support the traditional rule that an insurer has the right to rely on the insured’s truthfulness when completing the application.

The principal and oft-cited case in this regard is \textit{Wesley v. Union National Life}.\textsuperscript{143} Thomas Wesley purchased a whole life insurance policy, naming his mother as beneficiary.\textsuperscript{144} He signed an application, falsely answering questions regarding any hospitalizations, cocaine or heroin use, and physician consultations within the prior three years.\textsuperscript{145} The insured was fatally shot shortly after purchasing the policy.\textsuperscript{146} The coroner found cocaine in Wesley’s blood.\textsuperscript{147} The insurer investigated and only then learned that Wesley was confined in a hospital’s chemical dependency unit for cocaine addiction.\textsuperscript{148} The policy was rescinded, and this lawsuit followed.\textsuperscript{149} Plaintiff argued, citing \textit{Lewis}, that the insurer violated Mississippi law because it engaged in post-claim underwriting.\textsuperscript{150}

The district court disagreed and granted the insurer’s motion for summary judgment, noting that questions on an insurance application are one method to screen out applicants who present unacceptable risks.\textsuperscript{151} An insurance company has the right to rely on the information supplied in the application in determining whether or not to accept the risk.\textsuperscript{152} Here, the insurer had an underwriting policy not to accept individuals answering yes to any of the application questions. In answering three of these questions falsely, “the insured bypassed the [insurer’s] underwriting process.”\textsuperscript{153} The law grants an insurance company the right to rescind coverage when an applicant makes material misrepresentations in the application.\textsuperscript{154}

The court recognized that there is an important difference between a claim investigation and underwriting a policy after the fact. The court noted that

\begin{quote}
plaintiff appears to confuse post claim underwriting with post claim investigation of eligibility. To deny the [insurer] the right to engage in post claim
\end{quote}

\textsuperscript{143} 919 F. Supp. 232 (S.D. Miss. 1995).
\textsuperscript{144} Id at 233.
\textsuperscript{145} Id.
\textsuperscript{146} Id.
\textsuperscript{147} Id.
\textsuperscript{148} Id.
\textsuperscript{149} Id.
\textsuperscript{150} Id.
\textsuperscript{151} Id. at 234.
\textsuperscript{152} Id.
\textsuperscript{153} Id. at 235.
\textsuperscript{154} Id.
investigation would mean that insurers would have to investigate every answer by every applicant before insuring them and to pay claims regardless of the misrepresentations contained in the application.\textsuperscript{155}

The insured's misrepresentations, not the acts of the insurer, denied his designated beneficiary the life insurance benefits altogether.\textsuperscript{156}

The \textit{Wesley} court's distinction between post-claim investigation and post-claim underwriting defines the premise of this article. As long as the insurer asks questions on the application that will enable it properly to underwrite the risk and the applicant is placed on notice through these questions that specific medical, employment, and personal information must be disclosed, the insurer reserves the right to investigate the accuracy of these responses at a later date, including a time period after a claim for benefits is received. As long as the insurer satisfies the particular state law governing the policy, rescission of coverage is justified.

Other recent court decisions have followed \textit{Wesley}.\textsuperscript{157} In \textit{Northwestern Mutual Life Insurance Co. v. Babayan},\textsuperscript{158} the U.S. Court of Appeals for the Third Circuit affirmed the district court's summary judgment in favor of the insurer, finding that the insured committed bad faith as a matter of law when completing her application.\textsuperscript{159} The court stated, "[W]e conclude that the District Court did not err in granting summary judgment in favor of [the insurer] with respect to [plaintiff's] novel bad faith claim premised upon [the insurer's] 'post-claim underwriting' practices."\textsuperscript{160}

Here, the insured applied for a disability income insurance policy and completed an application, responding to a number of questions that re-

\begin{itemize}
\item \textsuperscript{155} Id. at 235 n.3.
\item \textsuperscript{156} Id. at 235. \textit{But see} Hailey v. Cal. Physicians' Serv., 69 Cal. Rptr. 3d 789, 799–800 (Ct. App. 2008) (criticizing distinction between post-claims "underwriting" and post-claims "investigation" and stating that "[t]he distinction between [the two concepts] thus lies primarily in the quality of the underwriting process undertaken before the policy is issued").
\item \textsuperscript{157} 919 F. Supp. 232 (S.D. Miss. 1995). The federal district courts interpreting Mississippi law continue to reject the \textit{Lewis} decision. \textit{See} Guideone Mut. Ins. Co. v. Rock, No. 1:06-CV-218-SA-JAD, 2009 WL 2252204, at *8 n.6 (N.D. Miss. July 28, 2009) (rejecting the insured's post-claim underwriting argument, noting that under \textit{Wesley} an insurer, if it could not rely on the representations contained in the application, would be required to investigate every response prior to issuing coverage or risk having to pay claims even when the insured misrepresented his health); \textit{see also} Brown v. Empire Fire & Marine Ins. Co., No. 3:07cv644 DPJ-JCS, 2009 WL 2242437, at *1–2 (S.D. Miss. July 24, 2009).
\item \textsuperscript{158} 430 F.3d 121 (3d Cir. 2005).
\item \textsuperscript{159} Id. at 124. The issue of the insured's bad faith in the context of rescission differs from the duties owed by an insurer to the insured. Here, Pennsylvania law, in order to rescind coverage, requires the insurer to establish that the insured's representation on the application was false when made or that the insured made the representation in bad faith. \textit{Id.} at 129. This is in addition to the requirement of materiality. \textit{Id.}
\item \textsuperscript{160} Id. at 123.
\end{itemize}
quired either a yes or no response. 161 Two questions, one asking for any motor vehicle accidents within the past five years and another asking for any medical advice or treatment within the past ten years for arthritis, sciatica, gout, or any disorder of the muscles, bones, joints, spine, or back, were answered in the negative. 162 Both responses were false. 163

The insured also underwent a paramedical examination where she once again was asked questions similar to the agent’s inquiries. She again signed a questionnaire that contained false answers. 164 Based on this information, the Northwestern underwriter did not feel it necessary to obtain any medical records and approved the application. 165

Approximately one year later, the insured applied for disability benefits due to fibromyalgia. 166 The insurer then began a contestability investigation because it was the company’s routine practice to do so for any claim filed within the first two years of coverage. 167 This investigation uncovered the undisclosed automobile accident as well as extensive treatment for chronic pain, disc disease, and right knee degeneration, resulting in the policy being rescinded. 168 The insurer then proceeded to file a lawsuit seeking a declaratory judgment regarding its right to rescind coverage. The insured counterclaimed. 169 Summary judgment was awarded to the insurer and the selling agent. 170

The Third Circuit addressed the insured’s argument that the insurer’s post-claim underwriting was illegal. Specifically, the insured argued that the Third Circuit “should predict that the Pennsylvania Supreme Court would conclude that ‘post-claim underwriting’ may constitute bad faith.” 171 She cited Lewis 172 and a law review article 173 arguing that this practice should be declared per se illegal. The Third Circuit rejected the insured’s argument, citing in part the decision in Wesley: 174

We note that the concept of “post claim underwriting” itself is nebulous, particularly because it is difficult to draw a distinction between post-claim

\[\text{\textsuperscript{161}}\text{Id. at 124.}\]
\[\text{\textsuperscript{162}}\text{Id. at 124–25.}\]
\[\text{\textsuperscript{163}}\text{Id. at 125.}\]
\[\text{\textsuperscript{164}}\text{Id. at 126.}\]
\[\text{\textsuperscript{165}}\text{Id.}\]
\[\text{\textsuperscript{166}}\text{Id. at 127.}\]
\[\text{\textsuperscript{167}}\text{Id.}\]
\[\text{\textsuperscript{168}}\text{Id.}\]
\[\text{\textsuperscript{169}}\text{Id. at 127–28.}\]
\[\text{\textsuperscript{170}}\text{Id. at 128.}\]
\[\text{\textsuperscript{171}}\text{Id. at 137–38.}\]
\[\text{\textsuperscript{172}}637 \text{So.} 2d 183 (Miss. 1994).\]
\[\text{\textsuperscript{173}}\text{Cody & Gates, supra note 14.}\]
\[\text{\textsuperscript{174}}430 F.3d at 138 n.23.}\]
eligibility investigation and post-claim underwriting. For example, Pennsylvania law provides that it is not bad faith to conduct a thorough investigation into a questionable claim. [The insured's] concept of “post-claim underwriting” would usurp this general principle and prevent insurers from engaging in post-claim investigations, even in the fact of incontrovertible evidence that an insured made a clear misrepresentation.175

Furthermore, unlike Lewis,176 where the insurer relied only on the application to accept the insured, the court noted that Northwestern also relied on the nonmedical questionnaire and paramedical exam. Based on all of this information, a decision was made not to obtain medical records.177 Accordingly, the insured’s responses constituted “one method for screening out applicants who presented unacceptable risks.”178 “The court noted “[t]he fact that someone with the title of ‘underwriter’ was involved in the investigatory process does not transform a permissible post-claim investigation into impermissible post-claim underwriting.”179

Other courts have considered and rejected plaintiff arguments that post-claim underwriting is illegal without citing Lewis180 or Wesley.181 In Hussey v. Fidelity & Guaranty Life Insurance Co.,182 the insured applied for a life insurance policy and completed an application that contained multiple inquiries regarding the applicant’s medical history, to all of which she responded in the negative.183 In between the application and actual issuance and delivery of the policy, the insured visited a doctor and ultimately learned that she had hepatitis C. This condition was never disclosed to the insurer, and coverage was issued.184 The insured was killed in a motor vehicle accident within the contestable time period. The insurer, upon receiving a claim for death benefits, “conducted a routine contestable claim investigation.”185

175. Id. at 138.
176. Id.
177. Id.; see also Am. Gen. Life Ins. Co. v. Garcia, No. 07–3179 (RMB/KMW), 2009 WL 2905372 (D.N.J. Sept. 10, 2009) (permitting insurer to rescind coverage where insurer issued coverage based solely on a signed application and paramedical exam conducted at the insured’s home, and only after insured died and litigation commenced did insurer first learn of material misrepresentations contained in the application (and possibility of an imposter applying for coverage)).
178. 637 So. 2d 138, 138 (Miss. 1994).
179. Id. at 139; see also Cummings v. Am. Gen. Life Ins. Co., No. 06–3468, 2008 WL 1971323 (E.D. Pa. May 6, 2008) (upholding insurer’s decision to rescind where applicant failed to disclose cocaine use and insurer conducted “routine investigation” following insured’s death from a gunshot wound during the contestable time period).
180. 637 So. 2d 183 (Miss. 1994).
183. Id. at 495–96.
184. Id. at 496.
185. Id. at 496–97.
The beneficiary, upon being notified that coverage was rescinded, sued, alleging, in part, illegal post-claim underwriting. The rescission was upheld, and the court did not question such an investigation.

Likewise, *John Hancock Mutual Life Insurance Co. v. Banerji* rejected the insured’s allegations that post-claim underwriting is illegal. Specifically, the Massachusetts Supreme Court stated that

[t]o accept Banerji’s argument that Hancock was obligated to investigate all of Banerji’s (or any other insured’s) statements on an . . . application for insurance benefits when submitted would impose an enormous burden on insurers, a burden that attachment [of the application to the policy] statutes are designed to obviate."

The court went on to say that “[i]t appears from the record that Hancock did nothing more than undertake a routine evaluation of Banerji’s claim when the claim for disability benefits was submitted. It was entitled to do so here.”

Similarly, in *Hornback v. Bankers Life Insurance Co.*, the court rejected plaintiff’s argument that post-claim underwriting is illegal. There, the Hornbacks purchased a pickup truck along with credit life and disability insurance to protect the car loan. At the time of purchase, Mr. Hornback signed an application representing, among other things, that within the past sixty months he had not been treated for or diagnosed as having any disease of the heart. Approximately eighteen months later, Hornback be-

186. *Id.* at 497.
187. *Id.* at 500–01. At the time the application was completed, the insured responded that she did not have nor had she been treated for hepatitis. Soon thereafter, the insured visited a doctor and disclosed that she had previously engaged in IV drip use. The doctor tested for and confirmed that she had hepatitis C. This information was never provided to the insurer, which subsequently issued coverage. The policy provided that her health must be as represented at the time of delivery of the policy. At no time had the insurer independently investigated her health history. Upon her death, the insurer discovered this medical condition and rescinded. The federal district court upheld the rescission. *Id.* Similarly, in *West v. Wilton Reassurance Life Insurance Co. of New York*, 601 F. Supp. 2d 1133 (W.D. Mo. 2009), the insured electronically submitted an application for a $150,000 life insurance policy. The application was checked no in response to a question about hospital confinement. In fact, he was hospitalized for a brain tumor on the day that the application was submitted. The insurer’s underwriting system would automatically issue coverage if the application questions were answered no and reject applications with a yes response. Accordingly, coverage was issued. *Id.* at 1134–35. The insured died one year later, and the court upheld the insurer’s right to rescind, without questioning whether the insurer had any obligation to investigate the application responses prior to issuing coverage. *Id.* at 1137–38.
188. 858 N.E.2d 277 (Mass. 2006).
189. *Id.* at 287 n.19.
190. *Id.*
192. *Id.* at 700.
193. *Id.*
came disabled due to congestive heart failure and sought benefits under his policy. The insurer conducted an investigation and only then learned that Hornback had been under medical treatment for a previous heart attack.\footnote{194} Coverage was rescinded, and this lawsuit followed.\footnote{195} Defendants sought summary judgment, which the trial court granted.\footnote{196}

On appeal, the Hornbacks argued in part that the insurer engaged in illegal post-claim underwriting. The insurer “merely move[d] that underwriting process to the period of time following the claim.”\footnote{197} The appellate court rejected this argument, stating thus:

[Post-claim underwriting] has not been adopted by Kentucky courts. \[A Kentucky statute\] provides that an insurer may underwrite risks on an individual basis. The questions contained on the application are intended to elicit information for this purpose. An insurance company that issues a policy based on the applicant’s answers, without any investigation, is not precluded from raising the defense of fraud or material representation. . . . When an insured misrepresents material facts on the application, the insurer is justified in denying coverage and rescinding the policy. Such is the case here.\footnote{198}

The court permitted the insurer to rescind coverage based solely on the application misrepresentations,\footnote{199} unlike \textit{Babayan}, in which the court indicated that the insurer also had conducted a paramedical exam.

In \textit{Brandt v. Time Insurance Co.},\footnote{200} an insurance agent completing a client’s application for health insurance answered no to the question of whether the applicant suffered from certain identified illnesses, including diabetes.\footnote{201} Following a policy claim, the insurer learned of the policyholder’s diabetic condition and rescinded coverage.\footnote{202} Among other claims, the policyholder alleged that the insurer’s practice of post-claim underwriting constituted common law fraud and a violation of the Illinois Unfair Trade Practices statute.\footnote{203} The court rejected plaintiff’s claims, noting that “the insurer has no general duty to investigate the truthfulness of answers given to questions asked on an application for insurance.”\footnote{204} The court added

\footnote{194. \textit{Id.} at 701.}
\footnote{195. \textit{Id.}}
\footnote{196. \textit{Id.}}
\footnote{197. \textit{Id.} at 704.}
\footnote{198. \textit{Id.} at 705.}
\footnote{199. \textit{Id.}}
\footnote{200. 704 N.E.2d 843 (Ill. App. Ct. 1998).}
\footnote{201. \textit{Id.} at 845.}
\footnote{202. \textit{Id.}}
\footnote{203. \textit{Id.} at 846. Specifically, Brandt alleged that “an insurer must investigate the information on an application before, or within a reasonable time after, issuing a policy. . . . [I]ssuing a policy and then waiting until a claim is made before investigating the insurability of the applicant perpetrates a fraud upon the applicant and the public.” \textit{Id.}}
\footnote{204. \textit{Id.}}
that “‘[a]n insurance company has the right to rely on the truthfulness of the answers given by an insurance applicant, and the insured has the corresponding duty to supply complete and accurate information to the insurer.’” Therefore, the court declined to hold post-claim underwriting to be unlawful.

Still other courts, without specifically referencing post-claim underwriting, support the insurer’s right to investigate an insured’s application at claim time. In *In re Tri-State Armored Services*, applying New Jersey law, the court held that an insured has the duty to provide thorough and complete information on an insurance application. The insurer’s failure to investigate does not prevent the insurer from reasonably relying on the presumed truthfulness of the application’s information. This rule applies even if the insurer acted negligently in investigating the application’s responses. An insurer who engages in poor underwriting practices does not forfeit its right to rescind a policy if the insured has misrepresented material information on the policy.

Similarly, the *Tri-State Armored Services* court in an earlier opinion addressed the bankruptcy trustee’s attack on an insurer’s post-claim investigation of a claim, stating thus:

[N]o New Jersey authority has been cited or found for the proposition that underwriting deficiencies prior to policy [approval], followed by aggressive post-loss investigation aimed at supporting coverage denial, defeats rescission.
In New Jersey, the emphasis is on the applicant to provide truthful and complete answers to questions on an insurance application.213

In *Rassler v. General American Life Insurance Co.*,214 the insured’s death certificate indicated that the insured died in part due to a disease not listed in the application.215 The disease had existed for years. The insurer stated that it was standard practice for it and other insurers to undertake an eligibility investigation to determine whether to contest the policy if the insured dies within the two-year time period.216

Here, the insurer conducted an investigation and ultimately paid the claim.217 The beneficiary sued, alleging that the insurer’s delay constituted bad faith.218 The district court found that the delay was reasonable because of information contained in the death certificate and because the insured died within the contestability period.219 “Undertaking an investigation during the contestability period is not a breach of any duties and further, it is a customary practice in the insurance field.”220 The insurer had the right to investigate. “The court finds as a matter of law that coverage was not reasonably clear from the documents, and therefore, there is no evidence that the [insurer] failed to pay the claim after coverage had become reasonably clear.”221

In *First Penn Pacific Life Insurance Co. v. Evans*,222 the insurer rescinded coverage based solely on information obtained after the policy was issued.223 The beneficiaries argued that the insurer waived its right to rescind because it negligently evaluated the insured’s application.224 The district court noted that the “overwhelming weight of authority holds that an insurer generally does not have an obligation to investigate the truth of statements made in an application for insurance.”225

---

213. *Id.* at 729.
215. *Id.* at 693.
216. *Id.*; see also *Johnson v. Conn. Gen. Life Ins. Co.*, No. 08–3347, 2009 WL 928590, at *7 (6th Cir. Apr. 7, 2009) (holding that insurer abused its discretion in rescinding coverage but not because insurer conducted post-claim investigation)
217. 561 F. Supp. 2d at 693.
218. *Id.* at 693–94.
219. *Id.* at 695–96.
220. *Id.* at 695.
221. *Id.* at 696.
223. *Id.* at *5.
224. *Id.* at *7 n.13.
225. *Id.* at *7. The district court barred rescission, however, on the basis that the insurer failed to initiate a judicial proceeding within the two-year contestable time period as required under Arizona law. *Id.*
Likewise, in *Dracz v. American General Life Insurance Co.*, the insured failed to disclose in response to a specific application question that he had been convicted of driving under the influence of alcohol within the past five years. The insurer’s representative testified that had the insured truthfully disclosed his conviction, the life insurance policy applied for would not have been issued. The insurer was permitted to rescind. There is no evidence or discussion about the insurer’s failure to conduct a preissue investigation regarding the insured’s driving record.

In *Scottsdale Insurance Co. v. Tolliver*, the court rejected the insureds’ argument that by failing to conduct a timely investigation of their application prior to issuing coverage, the insurer acted in bad faith by rejecting their claim:

> The [insureds] claim that Scottsdale had a duty to conduct an adequate investigation, and they argue that Scottsdale acted in bad faith by initially failing to investigate the facts in [their] application. . . . An insurer cannot be held liable for bad faith by failing to investigate the factual statements in an application for insurance coverage. . . . [The insurer] had no legal duty to investigate the [insureds'] application for factual misrepresentations or inaccuracies. Therefore, failure to do so does not create a basis for a bad faith claim under Oklahoma law.

In a subsequent opinion, the *Scottsdale* court stated that “[the insurer] was permitted, for purposes of a bad faith claim, to rely on the truthfulness of the application without investigating the facts stated on the application.”

In *Harris v. Transamerica Life Insurance Co.*, the insured applied for a life insurance policy but failed to disclose in response to a specific application question that he had alcohol-related liver cirrhosis. His policy subsequently lapsed, and his reinstatement application again failed to disclose this health condition. He died within the contestable time period. The insurer, upon discovering this health problem, rescinded coverage for

---

227. *Id.* at 1167.
228. *Id.* at 1170. The insured died within the contestable time period of the life insurance policy. Only then did the insurer investigate the representations contained in the application and learned that the insured failed to disclose the fact that he had been convicted for driving under the influence of alcohol within the five-year period preceding the purchase of the insurance. Based on this newly discovered information, the insurer rescinded coverage. *Id.*
230. *Id.* at 1252.
233. *Id.* at *1.
234. *Id.*
material misrepresentation. The court, affirming the insurer’s decision to rescind, stated that “[a]n insurance company has the right to rely on statements made in the application regardless if the statement was made in good faith.”

Marshall v. Universal Life Insurance Co. involved an applicant who purchased a life insurance policy on behalf of her three-year-old child and answered no to the application’s inquiry as to whether the child had visited a physician during the past five years, when the child actually had visited a physician twenty-one times during her short life. Following the child’s death, the insurer discovered the misrepresentation and denied coverage. The Oklahoma appellate court reversed a bad faith judgment regarding the denial of the claim. The court rejected the mother’s claim that the insurer had a duty to discover the misrepresentation at the time the policy was issued, instead noting that the insurer retained “the contractual and statutory right to investigate the claim when it was made.” The court also found that the failure to conduct a preissue eligibility investigation did not bar the insurer’s right to rescind. That issue, however, remained a factual question because Oklahoma requires an insurer to prove that the insured had an intent to deceive when completing the application.

These and other decisions clearly support an insurer’s right to conduct a post-claim investigation regarding the truthfulness of an insured’s application responses. This is especially true when the insured fails to disclose any adverse health history.

D. Post-Claim Underwriting as a Company-Wide Cost Containment Practice

A number of courts have concluded that in certain circumstances insurers may not use the practice of post-claim underwriting to deny coverage

---

235. Id.
236. Id. at *2 (citing Wesley v. Union Nat’l Life, 919 F. Supp. 234 (S.D. Miss. 1995)).
238. Id. at 652.
239. Id.
240. Id. at 654.
241. Id. at 653.
242. Id. (“Universal was under no duty at [the time of application] to discover whether or not the ‘no’ answer was a misrepresentation. It did, however, have the contractual right to investigate the claim when it was made.”).
243. Id. at 654.
Post-Claim Underwriting

based upon material misrepresentations or omissions made in the policy application. These decisions appear to support the plaintiffs’ position of illegality. Upon closer examination, however, these opinions actually do not support the Lewis decision that this conduct by itself is illegal.

These courts instead have focused not on the insurer’s right to investigate a specific insured’s application responses but on an insurer’s company-wide practice to use post-claim underwriting as a means to an end: cost containment and profit maximization. The challenged conduct includes practices when insurers have experienced severe financial losses and post-claim underwriting allows these companies to increase revenues by accepting new insureds while decreasing its expenditures by denying coverage when claims are submitted. Similarly, insurers that link an employee’s job or compensation to his or her ability to cancel coverage are subject to challenge. This includes insurer practices of establishing a bonus plan, which requires each underwriter or claims adjuster to satisfy certain criteria such as underwriting or adjusting a specified number of policies each day with the explicit or implicit understanding that higher rewards (or job-retention decisions) are made for rescinding coverage. Judges and juries have uniformly and justifiably condemned such conduct.


245. 637 So. 2d 183 (Miss. 1994).

246. Id. at 188–89.


248. For example, in White, 831 F. Supp. at 1556, there was evidence that underwriters were under a “bonus plan” that required them to earn 100 points per day to maintain their jobs. If the underwriter paid or denied a claim, it was awarded 2.5 points, but five points were awarded for each rescission. This plan permitted the insurer, which suffered severe financial
Recently, in *Mitchell v. Fortis Insurance Co.*,249 the South Carolina Supreme Court challenged the practice of post-claim underwriting. The court’s criticism, however, was directed at the insurer’s claims handling conduct once new information was received after the claim had been filed and not the insurer’s ability to seek medical information for the first time once the claim was filed.

In the case, Jerome Mitchell Jr., a seventeen-year-old, was no longer covered under his parent’s health insurance.250 On May 15, 2001, he applied to Fortis for an individual policy, completing and signing an application representing, among other things, that he had not been diagnosed with or received treatment for any immune deficiency disorder.251 Coverage was issued based on his answers contained in the application.252

Approximately one year later, Mitchell attempted to donate blood. On May 13, 2002, the Red Cross notified Mitchell that his blood tested positive for HIV.253 His personal physician one day later confirmed the diagnosis.254 Unfortunately, the doctor’s medical chart incorrectly recorded the date of treatment as May 14, 2001, and not 2002.255

Mitchell began medical treatment and submitted claims to Fortis.256 Fortis, in turn, began an eligibility investigation and obtained Mitchell’s physician’s notes.257 This information was provided to a senior underwriter who, based on the doctor’s notes that the diagnosis of HIV occurred prior to application, prepared a “referral summary” to the company’s rescission committee, recommending the policy be rescinded.258

The rescission committee thereafter rescinded coverage.259 A letter was sent to Mitchell, providing him the opportunity to provide additional in-

---

250. Id. at 180.
251. Id.
252. Id.
253. Id.
254. Id.
255. Id.
256. Id.
257. Id.
258. Id.
259. Id. at 180–81.
Mitchell attempted unsuccessfully to contact Fortis to correct the date of first diagnosis and then requested assistance from his medical provider. Once again, Fortis refused to acknowledge the incorrect treatment date. Finally, Mitchell’s attorney wrote to Fortis without success. This lawsuit followed, and the jury awarded substantial contract, compensatory, and punitive damages that, with a remittitur of the punitive damages award, was affirmed by the state’s supreme court.

Fortis, on appeal, in part, challenged the trial court’s decision to admit evidence regarding post-claim underwriting on the ground that such conduct is legal. The court rejected this argument, stating that “in the context of this case, Fortis’s post-claim underwriting practices played a pivotal role in the harm inflicted upon Mitchell in South Carolina. This evidence was probative of Fortis’s bad faith conduct, and was properly submitted to the jury.”

The post-claim conduct that the South Carolina Supreme Court found to be improper actually pertained to a concerted effort by Fortis to ignore post-claim information that directly contradicted evidence supporting its decision to rescind coverage. The initial medical records received during the post-claim investigation supported Fortis’s decision that a material misrepresentation had been made on the application. However, all subsequent efforts to correct this medical diagnosis date by Mitchell, his health care provider, and even his attorney were summarily rejected without any further investigation. Each time, Fortis’s only response was that nothing could be done. Even when actually provided with the corrected date of diagnosis, the rescission committee stood firm on its decision after only a very brief review of the materials.

Mitchell introduced evidence at trial through an insurance expert witness “that it was Fortis’s practice to shut down an investigation once a single piece of evidence was discovered that would support rescission.” Additionally, Fortis failed to produce the senior underwriter at trial to justify her conduct. The underwriter’s failure to testify justified the jury

---

260. Id. at 181.
261. Id.
262. Id.
263. Id.
264. Id. at 189–90. For a similar factual setting and resulting damages, see United American Insurance Co. v. Merrill, 978 So. 2d 613 (Miss. 2007), and supra note 118.
265. 686 S.E.2d at 189.
266. Id.
267. Id. at 180–81, 186.
268. Id. at 180–81.
269. Id. at 180–81, 188–89.
270. Id. at 181.
271. Id. at 186.
in reaching a negative inference.\textsuperscript{272} Nor could Fortis’s witnesses explain whether the company “had a responsibility to find out the truth.”\textsuperscript{273} In other words, “[i]t was reasonable to conclude . . . that Fortis was motivated to avoid the losses it would undoubtedly incur in supporting Mitchell's costly medical condition.”\textsuperscript{274}

V. CALIFORNIA

A. Insurance Code: Post-Claim Investigation

A number of recent California decisions, like other state and federal opinions discussed previously, have refused to outlaw an insurer’s post-claim investigation resulting in policy rescission. Recently, in \textit{American General Life Insurance Co. v. Green},\textsuperscript{275} the insurer was granted a declaratory judgment allowing it to rescind a life insurance policy based on material misrepresentations contained in the application.\textsuperscript{276} Specifically, Green applied for a $250,000 life insurance policy, completing an application that, among other things, asked about his use of alcohol or drugs, including cocaine, marijuana, heroin, or other controlled substances. He responded no. The application also stated that he represented that his responses were true and complete to the best of his knowledge and that any misrepresentation made, and relied on by the company, could be used to void the policy.\textsuperscript{277}

Green died within the contestable time period, and once a claim for benefits was received, the insurer conducted a “contestable claim investigation.”\textsuperscript{278} The insurer determined that Green did not truthfully disclose his regular use of marijuana, as well as his previous use of methamphetamine, codeine, hydrocodone, and Xanax. Had this information been provided, coverage would not have been issued.\textsuperscript{279} Accordingly, the insurer, based solely on this information discovered after the policy was issued, rescinded coverage.\textsuperscript{280}

The beneficiary did not dispute the insured’s drug use but argued that the insurer was prevented from rescinding coverage because it failed to

\textsuperscript{272} Id.
\textsuperscript{273} Id. at 181.
\textsuperscript{274} Id. at 186.
\textsuperscript{275} No. 2:06-cv-02048-MCE-KJM, 2008 WL 2096833 (E.D. Cal. May 16, 2008).
\textsuperscript{276} Id. at *9.
\textsuperscript{277} Id. at *1.
\textsuperscript{278} Id. at *2.
\textsuperscript{279} Id.
timely investigate his application responses. The court rejected this assertion, noting that “[n]o authority is cited and none will be found holding that an insured or his beneficiaries may escape the consequences of his deception by placing upon the insurer the burden of investigating his verified statements.”

In *Yang v. Peoples Benefit Insurance Co.*, the insured died within the policy’s two-year contestable time period, so the insurer conducted “a standard contestable investigation, which included obtaining and reviewing [the insured’s] medical records and obtaining an underwriting review of the medical records that existed prior to the date of the application.” The court noted that such investigations are utilized during the contestable time period to determine whether the policy would have been issued as applied for had the insured fully disclosed his or her medical history on the application.

Likewise, in *West Coast Life Insurance Co. v. Ward*, the court upheld an insurer’s right to rescind a life insurance policy based on material misrepresentations contained in the application even though the insurer failed to investigate inconsistent responses in the application prior to issuance of coverage. When an insurer has demanded answers to specific questions on an application, such is usually sufficient to establish materiality as a matter of law. The court rejected plaintiff’s argument that inconsistent answers on the insurance application should have prompted the insurer to inquire as to the actual facts.

Finally, in *Kirsh v. UNUM Life Insurance Co. of America*, a disability insurance applicant answered no to an application inquiry as to whether he had been treated for digestive system problems in the past five years despite the fact that he had been diagnosed with irritable bowel syndrome and colitis and had been advised to undergo a colonoscopy. Shortly after

---

282. *Id.* at *8; see also Unionamerica Ins. Co., Ltd. v. Fort Miller Group, Inc., No. C05–1912 BZ, 2009 WL 688873, at *6 (N.D. Cal. Mar. 16, 2009) (remarking that “[t]he few courts that interpreted [California Insurance Code] section 332 have not interpreted it to impose on the insurer an affirmative duty to investigate that overrides the insured’s duty of disclosure”).
284. *Id.* at *2.
285. *Id.*
286. 33 Cal. Rptr. 3d 319 (Ct. App. 2005).
287. *Id.* at 324–25.
288. *Id.* at 323.
289. *Id.* at 324 (“Our analysis . . . begins with the concept of materiality . . . [T]he question becomes whether the discovery of [an] immaterial omission [in the application] implied the existence of other material nondisclosures. We think the answer is surely no.”).
291. *Id.* at *1.
the policy was issued, the policyholder was diagnosed with colon cancer.292 The insurer only then learned of the policyholder’s misrepresentations and rescinded the policy.293 Plaintiff alleged, in part, that the insurer engaged in illegal post-claim underwriting.294 The court, affirming the trial court’s summary judgment ruling for the insurer, stated that “. . . [i]f [the plaintiff] disclosed the . . . test and its results, UNUM certainly would have investigated, obviating any problem of ‘post-claim underwriting.’ . . . In short, [plaintiff] cannot take advantage of his own non-disclosure to manufacture defenses to rescission.”295

B. Health Care Service Plan Act

Recently, in contrast to the insurer’s right to initiate eligibility investigations even after a claim is filed, the issue of post-claim underwriting has been addressed by the California courts in the context of health care service plans.

1. Introduction

Health care service plans in California operate under the Knox-Keene Health Care Service Plan Act of 1975.296 The purpose of the act is “to promote the delivery and quality of health and medical care to the people of the State of California who enroll in, or subscribe for the services rendered by, a health care service plan or specialized health care service plan.”297 The act seeks 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.”298

Health care service plans are not considered to be insurance companies within the meaning of California Insurance Code § 1061.299 Insurers indemnify against loss, damage, and liability. Health care service plans arrange for health care services for their members through a contracted network of providers.300 However, because of the similarities to insurance companies, certain common law responsibilities, such as the duty of good faith and fair dealing, apply to health care service plans as they do to insurers.301

292. Id. at *2.
293. Id. at *3.
294. Id. at *4.
295. Id. at *7.
297. Id. § 1342.
298. Id. § 1342, subdiv. (d).
300. Hailey, 69 Cal. Rptr. 3d at 802–03.
2. Post-Issue Application Review

Health care service plans, like insurance companies, rescind coverage when they determine that a material misrepresentation has been made in the application. Unlike insurance companies, health care service plans are governed by statutes that restrict this ability to rescind. 302 “To prevent providers from shifting the financial risk of health care back to the subscribers, the [California] Legislature in 1993 enacted § 1389.3 as part of the Health Insurance Access and Equity Act,” 303 which defines *post-claims underwriting* as follows:

No health care service plan shall engage in the practice of postclaims underwriting. For purposes of this section, “postclaims underwriting” means the rescinding, canceling or limiting of a plan contract due to the plan’s failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the plan contract. This section shall not limit a plan’s remedies upon a showing of willful misrepresentation. 304

This section presents many questions regarding the duties and responsibilities of a health care service plan to screen applicants prior to issuing coverage and the consequences for failing to do so. How far must the underwriter’s investigation proceed? For example, what if the applicant does not disclose any medical problems inquired about on the application even though the applicant has signed the application attesting to the truthfulness of the statements contained therein? Should applicants themselves be interviewed to determine whether they knew what was expected of them in completing the application? Should an insurer be required to make follow-up inquiries regarding the applicant’s information submitted, including looking into possible omissions prior to issuing insurance? Should the family physician be contacted? Should other health care providers be sought out?

Claimants in these situations argue that the plan should not limit the insurer’s inquiry simply to reviewing the application for inconsistent or incomplete responses. 305 They point out that insurers as part of the ini-

---

302. *Id.* at 797–98, 801. However, because of the similarities to insurance companies, certain common law duties, such as the duty of good faith and fair dealing, apply to health care service plans as they do to insurers.

303. *Hailey*, 69 Cal. Rptr. 3d at 798 (citing 1993 Cal. Stat., ch. 1210, § 3, art. 7.5).


tional underwriting process often review internal claim databases, including pharmacy and motor vehicle records for health and driving information.306 This information is in addition to that furnished by the applicant and is obtained with the applicant’s consent. Why not extend this investigation?307

Similarly, what happens when an applicant discloses certain medical issues in the application and the plan fails to follow up regarding any medical questions raised by those disclosures before issuing coverage and then later seeks to rescind based on those same conditions?308 If the information provided appears to be incomplete, must the underwriter follow up and resolve all reasonable questions concerning any medical issues disclosed in the application at the time of submitting the application? If not, can the plan be prevented from thereafter rescinding coverage based upon a post-issue investigation of those facts?309

These are important issues in light of § 1389.3.310 Yet, should not health care service plans, just like insurance companies, have the right to rely on the truthfulness of the application responses as submitted without further inquiry, even in light of the California statutory obligation to complete pre-enrollment underwriting? What will be considered a reasonable pre-issue investigation? Contacting physicians and other health care providers can be extremely time-consuming and expensive. Several state appellate court decisions have addressed these issues.

3. Hailey v. California Physicians’ Service

The California Court of Appeal in Hailey v. California Physicians’ Service311 decided that a different rule applies to health care service plans. The court held that if the plan does not complete medical underwriting prior to issuing the plan contract, it may rescind only upon a finding of willful miscon-
duct. The court further held that in order to complete preissue medical underwriting, the plan must make reasonable efforts to ensure that an application is accurate and complete. The state’s post-claim underwriting statute thus bans the practice of post-claims underwriting except when the member willfully misrepresents his or her health conditions on the application.

The factual background is straightforward. Cindy Hailey completed an application for her family seeking health insurance from Blue Shield. Coverage was issued on December 15, 2000, based on the responses contained in the application. Her husband thereafter developed stomach problems requiring hospitalization, which led Blue Shield to request and ultimately obtain Mr. Hailey’s medical records. On March 19, 2001, Steve Hailey became permanently disabled as a result of an automobile accident, which included a two-month hospital confinement. Prior to his discharge, Blue Shield had authorized health care providers to provide a variety of medical, surgical, and rehabilitation services in an amount exceeding $457,000 in hospital-contracted services.

On June 1, 2001, Blue Shield informed the Haileys that their health coverage had been cancelled retroactively to December 15, 2000, contending that Cindy Hailey had failed to disclose material medical information about her husband. Specifically, Blue Cross contended that she lied on the application about her husband’s preexisting medical conditions such as hypertension, obesity, difficulty swallowing, and gastroesophageal reflux disease. The undisclosed medical problems, according to Blue Shield, supported a decision to rescind coverage. The health plan also demanded that Steve Hailey repay more than $104,000 it actually had spent on his behalf. Cindy Hailey countered by stating that although she completed the application for her family, she mistakenly believed that it was asking for information only about her health, and the company’s agent who provided the application did not tell her otherwise.

---

312. Id. at 798–79.
313. Id. at 802.
314. Id. at 798.
315. Id. at 795–96.
316. Id. at 796.
317. Id.
318. Id.
319. Id.
320. Id.
321. Id.
322. Id.
323. Id.
The Haileys sued Blue Shield in the Orange County Superior Court for breach of contract, bad faith, and intentional infliction of emotional distress.\textsuperscript{324} Blue Shield moved for summary judgment, which the superior court granted, finding that the Haileys’ misrepresentations and omissions supported Blue Shield’s right to rescind. The court also entered judgment in favor of Blue Shield on its cross-complaint for $104,194, finding that the medical expenses must be repaid.\textsuperscript{325} When the Haileys could not make payments, Blue Shield began garnishing Cindy Hailey’s wages, and they appealed this decision.\textsuperscript{326}

The appellate court reversed and remanded the case for trial, holding that the Haileys had established that triable issues of fact existed regarding whether they willfully misrepresented Mr. Hailey’s medical history.\textsuperscript{327} Mrs. Hailey believed that the application sought only her health history information, and “Cindy’s explanation for omission of Steve’s information is not patently unbelievable.”\textsuperscript{328} The appellate court also issued a temporary hold on the garnishment.\textsuperscript{329}

The decision found that there were triable issues of fact regarding whether Blue Shield engaged in illegal post-claims underwriting.\textsuperscript{330} The Hailey court interpreted \textit{post-claims underwriting} to be when an insurer “wait[s] until a claim has been filed to obtain information and make underwriting decisions which should have been made when the application [for insurance] was made, not after the policy was issued.” In other words, the insurer does not assess the insured’s eligibility for insurance, according to the risk he presents, until after insurance has been purchased and a claim has been made. Although the insurer may ask an applicant for some underwriting information before it issues the policy, it will not follow up on that information until after a significant claim arises. Only after a claim has arisen will the insurer examine the application and request additional information to see whether the applicant could have been excluded from coverage. An insurer relying upon post-claim underwriting “instead of looking to pay the claim . . . look[s] for all the things in the application that [it] might be able to dig up . . . to rescind the policy.”\textsuperscript{331}

The court went on to state that [in] the present case, the record demonstrates Blue Shield conducted an extensive investigation into Steve Hailey’s medical history after receiving a
claim stemming from Steve’s hospitalization for intestinal ailments. In contrast, Blue Shield apparently did little or no investigation into whether the medical information Cindy provided on the application was accurate.\footnote{Id. at 799–800.}

According to the appellate court, Blue Shield simply assumed that the application was correct.\footnote{Id. at 800.}

Blue Shield asserted that the prohibition on post-claims underwriting in § 1389.3 does not affect its right to perform a post-claims investigation, especially when no problems were disclosed on the application.\footnote{Id.}

The court, however, rejected Blue Shield’s argument that this section imposes no obligation to investigate the accuracy of a potential subscriber’s application unless questions arise from the answers given. The court said that

\begin{quote}
[w]e agree nothing on the Haileys’ application raised any questions relating to Steve’s health. But can a provider “complete medical underwriting” within the meaning of Section 1389.3 by blindly accepting the responses on a subscriber’s application without performing any inquiry into whether the responses were the result of mistake or inadvertence?\footnote{Id. at 801.}
\end{quote}

The court noted how simple it would have been to contact Cindy Hailey, the family physician, or both for health information, especially since the plan had little problem obtaining this information once the claim was filed.\footnote{Id. at 801.}

The court cited “the likelihood of inadvertent error” and “the potentially catastrophic consequences of an applicant’s error in filling out the application” as grounds for holding that California’s law gives a health care service plan the duty “to make reasonable efforts to ensure it has all the necessary information to accurately assess the risk before issuing the contract.”\footnote{Id. at 801, 804.} In discussing the first prong, the appellate court interpreted the phrase \textit{complete medical underwriting} as used in § 1389.3 to require an affirmative showing that the plan had reasonable procedures in place to verify the completeness and accuracy of the application.\footnote{Id. at 802.}

\textit{Hailey} summarily rejected many cases addressing the fact that proper underwriting does not require insurers to verify applicant statements, absent some other circumstances, on the basis that those cases were decided under the California Insurance Code (specifically, § 331).\footnote{Id. at 802–03.} \textit{Hailey} is the
first decision by the California Court of Appeal to construe § 1389.3. Hailey holds that if a plan chooses to rely only on the information contained in the application, it risks losing its ability to later rescind (absent a willful misrepresentation) if it cannot demonstrate that it took reasonable steps to complete its medical underwriting.

The Hailey court recognized there is a strong public interest in preventing the harm to health plan members, health care providers, and the general public that results from post-claims underwriting. Accordingly, the court concluded, the plain language of § 1389.3 requires that plans exercise reasonable care to ensure the accuracy of a potential subscriber’s application as part of the underwriting process before the plan issues a contract. “The Knox-Keene Act’s express purpose in transferring the risk [of financial loss] from patients to health plans requires nothing less.” The unmistakable purpose of Section 1389.3’s prohibition on ‘postclaims underwriting’ is to prevent the unexpected cancellation of health care coverage at a time coverage is needed most.” At issue on remand is for the trial court to decide whether the Hailey family intended to deceive Blue Shield and whether Blue Shield completed its medical underwriting.

Hailey interpreted complete medical underwriting to require health care service plans to make “reasonable efforts” to verify the accuracy of applicant representations. Importantly, however, the court failed to explain or provide guidance concerning what efforts its rule requires, leaving the health care service plans without meaningful guidance. “Because the circumstances of each case vary, we do not precisely spell out what steps constitute a reasonable resolution. This will usually present a question of fact.” An insurer or health care service plan will never know whether its efforts to verify the accuracy of application responses were reasonable until decided by a court. The Hailey rule states that a plan’s unspecified steps will be judged only after the fact and then on a case-by-case basis.

---

340. No prior case interpreting § 1389.3 is cited, and in several parts of the opinion the Hailey court “interprets” what it believes this section means. For example, the court states that “to effectuate section 1389.3’s purpose . . . we interpret ‘medical underwriting’ to require a plan to make reasonable efforts to ensure a potential subscriber’s application is accurate and complete. Because the circumstances of each case vary, we do not precisely spell out what steps constitute a reasonable investigation. This will usually present a question of fact.” Id. at 802.

341. Id. at 802, 804.
342. Id. at 797–98.
343. Id. at 800.
344. Id. at 804.
345. Id. at 800–01.
346. Id. at 804.
347. Id. at 802.
348. Id.
Finally, the court also held that a triable issue of fact existed regarding whether Blue Shield acted in bad faith by delaying its decision to rescind the policy. The court noted that Blue Shield’s underwriting investigator’s testimony raised the possibility that the insurer did not immediately rescind contracts upon learning of potential grounds for rescission but rather waited until the claims submitted exceeded the monthly premiums being collected. “Specifically, Blue Shield first became suspicious that the Haileys may have withheld information relating to Steve’s medical condition in February 2001, but the company failed to notify the Haileys of a potential problem until it sent out its rescission letter almost four months later in June.”

4. Analysis of Hailey

Much of Hailey’s reasoning appears to be based on Barrera v. State Farm Mutual Automobile Insurance Co., an automobile liability insurance decision. There, plaintiff was injured in a collision and obtained a judgment against the driver, who was insured by State Farm under a liability policy. Plaintiff then sued State Farm to collect the judgment. State Farm was permitted to rescind the contract on the basis that its insured made misrepresentations in his application for coverage. The California Supreme Court reversed:

...if an automobile liability insurer can perpetually postpone the investigation of insurability and concurrently retain its right to rescind until the injured person secures a judgment against the insured and sues the carrier, then the insurer can accept compensation without running any risk whatsoever. Such a rule would permit an automobile liability insurer to continue to pocket premiums and take no steps at all to probe the verity of the application for the issued policy unless and until the financial interest of the insurer so dictated. Furthermore, under such a rule, the carrier would be permitted to deal with the insured as though he were insured, and thus to lead him to believe that he was in fact insured.

The court held that “an automobile liability insurer must undertake a reasonable investigation of the insured’s insurability within a reasonable period of time from the acceptance of the application and the issuance of a policy.” Furthermore, “[w]hether or not the automobile liability insurer has breached its duty to the public to make a reasonable investigation

349. *Id.* at 804.
350. *Id.* at 805–06.
351. *Id.* at 805.
353. *Id.* at 662.
354. *Id.* at 662–63.
355. *Id.* at 670.
356. *Id.* at 663.
within a reasonable time after issuance of the policy ordinarily constitutes a question for the trier of fact.\textsuperscript{357} The Hailey court, citing Barrera, noted that its interpretation of § 1389.3 is consistent with the California Supreme Court’s handling of post-claims underwriting in the automobile insurance arena, where Insurance Code § 331 applies.\textsuperscript{358}

Why did the Hailey court emphasize Barrera? Barrera was by its very own terms limited to the specific context of automobile liability insurance and, in particular, the unique public policy to ensure that coverage is available when an innocent third party is injured by an insured who, it is later discovered, made material misrepresentations on the application.\textsuperscript{359}

Moreover, Barrera’s discussion regarding the investigation obligations of an automobile liability insurer specifically noted that information on an applicant’s driving record is easily accessible at a very low cost from a database maintained by the Department of Motor Vehicles.\textsuperscript{360} There is no similar agency or database for verifying the medical history of all applicants. Accordingly, the burden and cost of investigating an applicant’s driving record, even when the application says that the driver has no prior history of traffic violations, are insignificant.\textsuperscript{361} This clearly is not true for the health care field. Obtaining medical records from physicians and hospitals can be expensive and extremely time-consuming.

Further, the Barrera decision protects not the offending insured but the innocent third party injured by the insured’s negligence.\textsuperscript{362} The Barrera court emphasized that the insurer would not forfeit its right to cancel the insurance policy due to misrepresentations or to seek recovery from the insured for the amounts paid to the injured party.\textsuperscript{363} In the context of health insurance, there is no innocent third-party victim of an insured’s conduct who needs to be compensated.

5. \textit{Callil v. California Physicians’ Service}

In \textit{Callil v. California Physicians’ Service},\textsuperscript{364} following Hailey,\textsuperscript{365} the California Court of Appeal found that a trier of fact reasonably could conclude

\textsuperscript{357}. \textit{Id.} at 681.
\textsuperscript{358}. 69 Cal. Rptr. 3d 789, 803 (Ct. App. 2008).
\textsuperscript{359}. 71 Cal. 2d at 670–72.
\textsuperscript{360}. \textit{Id.} at 667, 682. Importantly, it has been noted that the insurer’s obligation to investigate arises only after the policy is issued. Integon Preferred Ins. Co. v. Isztokia, No. 2:07-cv-00526-TMB/KJM, 2008 WL 5179094, at *6 n.43 (E.D. Cal. Dec. 9, 2008) (“Contrary to Interveners’ argument, there is no duty on the part of the insurer to investigate before it issues a policy.”) (citation omitted).
\textsuperscript{361}. 71 Cal. 2d at 667.
\textsuperscript{362}. \textit{Id.} at 677.
\textsuperscript{363}. \textit{Id.} at 681; \textit{see also Integon Preferred Ins. Co.}, 2008 WL 5179094, at *6.
\textsuperscript{365}. 69 Cal. Rptr. 3d 789 (Ct. App. 2008).
that Blue Shield failed to satisfy its duty to “complete medical underwriting” under California Health and Safety Code § 389.3. Therefore, Blue Shield could not rescind Callil’s plan contract unless her misrepresentations or omissions were willful, reversing a lower court’s grant of summary judgment in favor of Blue Shield on claims of breach of contract, bad faith, and punitive damages.

Callil involves the rescission of a health plan contract. Callil applied for an individual health plan with California Physicians’ Service d/b/a Blue Shield of California. Callil previously had been covered under a Blue Shield individual plan and currently was covered under a Blue Shield group HMO plan. Unlike an individual plan, her group plan did not involve individual underwriting. Thus, to qualify for the individual plan, Callil was required to submit a completed application seeking medical history information, including whether the applicant had been advised to obtain additional testing, treatment, or surgery not yet performed. Callil responded no to all questions. Blue Shield noted during the underwriting process that Callil had recently received emergency medical services, to which she responded that the incident involved pain cramps for which no treatment was provided. Although Callil signed a medical authorization for the release of medical information, Blue Shield did not contact her doctors prior to issuing coverage.

Soon thereafter, Callil’s doctor requested and received preauthorization to perform a hysterectomy. At the same time, Blue Shield referred the file to its underwriting investigative unit, per its standard procedure any time medical services are requested within the first two years of coverage. This unit requested information from a number of health care providers, which disclosed that Callil had a history of uterine fibroids and irregular menstrual bleeding, including a number of telephone conversations with her doctor in the weeks leading up to her application for coverage. Accordingly, the underwriting investigative unit determined that coverage would not have been issued had this information been disclosed on her application, and the contract was rescinded. In the meantime, Callil underwent the hysterectomy, incurring medical bills in excess of $50,000. Callil

367. Id. at *8.
368. Id. at *1.
369. Id.
370. Id.
371. Id. at *2.
372. Id.
373. Id.
374. Id.
375. Id. at *3.
challenged the rescission, but her internal appeal was denied, resulting in this lawsuit. 376

Blue Shield sought summary judgment, arguing that Callil's misrepresentations were material and her intent to deceive not relevant. Section 1389.3 was inapplicable because there were no “reasonable questions” presented in the application requiring resolution prior to issuing the plan contract. 377 Callil countered by arguing that a health care service plan’s right to rescind is controlled by this statute 378 and provided an affidavit that she failed to disclose these medical conditions because she simply considered them to be “a common, minor indisposition experienced by all women.” 379 Nor did she understand their significance in regard to obtaining coverage. 380

The trial court granted Blue Shield’s motion for summary judgment, finding that § 1389.3 was inapplicable. The court held that because Callil did not disclose any medical conditions on her application that required further underwriting by Blue Shield, there was no obligation to disbelieve Callil’s representations. 381 Where there is no disclosure that would put a reasonable insurer on notice of the need to conduct further investigation, there is no duty to investigate further. Thus, the traditional legal standards under California law for rescission applied. 382

The appellate court reversed, finding that the record disclosed triable issues of fact regarding whether Callil’s misrepresentations or omissions were willful and whether Blue Shield had completed its necessary medical underwriting as interpreted in the Hailey decision, including whether Blue Shield satisfied its duty to take reasonable steps to confirm the accuracy and completeness of Callil’s application. 383 Blue Shield already had in its

376. Id.
377. Id.
378. Id.
379. Id.
380. Id.
381. Id. at *4.
382. Id.
383. Id. at *8. The principles set forth in Hailey and Callil were affirmed in Nazaretyan v. California Physicians’ Service, 107 Cal.Rptr.3d 137 (Ct. App. 2010). Here, the trial court once again had granted summary judgment to Blue Shield following its rescission of a health care service plan issued to the Nazaretyans. Id. at 142. The California Court of Appeal reversed, ruling that Blue Shield failed to prove, as a matter of law, that its preissue investigation was adequate to establish that it completed all necessary medical underwriting, as required under Cal. Health & Safety Code § 1389.3. Id. at 144. Mrs. Nazaretyan failed to disclose previous infertility treatments on the application for coverage, which, according to Blue Shield, would have resulted in the denial of coverage. Id. at 141. She later gave birth prematurely to twin girls who were conceived as a result of in vitro fertilization. Id. The resulting claim triggered an investigation by Blue Shield’s eligibility review unit, which uncovered these preissue treatments, and coverage was rescinded. Id. The court, however, stated that Blue Shield had failed to set forth what, if any, efforts it undertook to investigate the accuracy of the application,
possession evidence that Callil’s representation regarding her last doctor visit was incorrect, yet there was no investigation. This could indicate to a judge or jury that complete medical underwriting had not been undertaken by Blue Shield. The appellate court also found that Blue Shield was not entitled to summary judgment on the bad faith and punitive damages claims.

C. Analysis of Open Issues

Along with the Hailey decision, will Callil’s requirement of preissue verification regarding the accuracy of representations made by applicants (even when the applications are “clean”) be limited to a health care service plan? For instance, § 1389.3’s unique statutory order of “no postclaims underwriting” points in that direction. Such controls should be limited to coverage falling within the Health and Safety Code. If so, its impact will be somewhat limited. The Knox-Keene Act has no Insurance Code § 331 counterpart. California Insurance Code § 332 obligates an applicant to disclose “all facts within his knowledge which are . . . material to the contract.” It is therefore generally accepted that an insurer has the right to know what the applicant knows regarding his or her health conditions referenced in the application. Misstatements or concealments, even if unintentional, of a material fact should still support a rescission because insurers in California need not establish an intent to deceive.

Moreover, if Hailey’s “reasonable efforts” standard is given a sensible construction, namely, that a plan must have a reasonable process to ensure the accuracy of applications (as opposed to verifying every statement in every application), most health plans have such a process in place. This would include obtaining medical records or recontacting the applicant other than confirming that no parts of the application were incomplete and reviewing its own internal systems. Nor did Blue Shield establish that the Nazaretyans willfully misrepresented any information. The case was remanded to the trial court.

385. Id. at *8.
386. Hailey v. Cal. Physicians’ Serv., 69 Cal. Rptr. 3d 789, 803 (Ct. App. 2008). In fact, this issue was discussed in Unionamerica Ins. Co., Ltd. v. Fort Miller Group, Inc., No. C05–1912 BZ, 2009 WL 688873, at *6 (N.D. Cal. Mar. 16, 2009). There, the court stated that under California law, “postclaim underwriting has been prohibited only in the context of some automobile insurance [Barrera], and health insurance [Hailey]. California courts have been hesitant to extend this prohibition to other areas of insurance.” Id. (citations omitted).
390. Hailey, 69 Cal. Rptr. 3d at 802.
where medical issues are disclosed on the application, where the application is not fully completed or contains inconsistent responses, or where the company is on notice of additional information through prior applications and/or claims by checking its own internal claim records. It is virtually impossible to independently verify each application response. 391

Yet, other language in Hailey, especially its evaluation of § 331, 392 could result in a far different future for this decision. Will courts extend this requirement to insurers? Will this bar all rights of insurers to rescind coverage because the “willful misrepresentation” safety valve found in the Health and Safety Code for health plans 393 is not included in the Insurance Code? If so, then all applications must be verified prior to policy issuance. In other words, insurers will not be permitted to rely on applicant representations when conducting their underwriting evaluations.

These are important questions because there is a very similar statute under the California Insurance Code, which states thus:

No insurer issuing or providing any policy of disability insurance covering hospital, medical, or surgical expenses shall engage in the practice of post-claims underwriting. For purposes of this section, “post-claims underwriting” means the rescinding, canceling, or limiting of a 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 prior to issuing the policy or certificate. 394

391. All insurers intending to underwrite an individual’s request for life and health insurance begin with an application seeking information about the applicant’s state of health. The application may be completed by the applicant and mailed to the insurer, completed by a sales agent during a face-to-face meeting, or completed by laptop computer. E.g., Stanford v. Veterans Life Ins. Co., No. Civ. A.1:91CV271-D-D, 1994 WL 1890816, at *2 (N.D. Miss. Oct. 24, 1994) (mailed application); Clark v. Old Mut. Fin. Network, No. 07cv4895, 2009 WL 2589499, at *1 (N.D. Ill. Aug. 19, 2009) (face-to-face meeting with agent); Neiman v. Am. Int’l Group, No. 1:cv-08–1535, 2009 WL 3764027, at *1 (M.D. Pa. Nov. 9, 2009) (computer application). Questions regarding the individual’s medical history and current state of health are included. Should the applicant respond to any question in the affirmative, he then must provide details, including the date(s); nature of the illness or injury; duration; severity; treatment; results; and identity of all treating doctors, hospitals, and/or clinics. The applicant also must attest that to the best of his knowledge and belief, all of the responses contained in the application are true and complete. See Thorpe v. Banner Life Ins. Co., 632 F. Supp. 2d 8, 14 (D.D.C. 2009). Some insurers follow up on the application by conducting a paramedical examination. The individual conducting this exam is not a physician and often a nurse. E.g., Neiman, 2009 WL 3764027, at *3. The applicant will be requested to once again verify the truthfulness of the information furnished in the application. Blood and urine samples may also be obtained. E.g., Old Mut. Fin. Network, 2009 WL 2589499, at *2.


394. Cal. Ins. Code § 10384. Two prior decisions have discussed this section. See Blue Cross of Cal., Inc. v. Superior Court, 102 Cal. Rptr. 3d 615 (2009) (where the Los Angeles
These issues have now been addressed and clarified in *Nieto v. Blue Shield of California Life & Health Insurance Co.* On May 5, 2005, Nieto, along with her domestic partner, David Moore, applied for an individual and family health plan with Blue Shield. Responding to specific questions contained in this application, they answered no to nearly every question, except Nieto and Moore answered yes to the questions 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. . . .” Moore responded that he had been diagnosed with a bulging disc 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 stated that her last doctor visit had occurred approximately three years earlier when she sought treatment for the flu with Dr. Abelardo Pita, and her health was “good.” She denied taking any prescription medication within the past twelve months. Finally, Nieto signed the application directly below an attestation clause that stated thus:

I have read the . . . terms and conditions of coverage and authorizations set forth above. I understand and agree to each of them. I alone am responsible for the accuracy and completeness of the information provided in this application. 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 coverage is issued, it may be cancelled or rescinded upon such a finding.

Upon receipt of the application, Blue Shield found certain information missing and contacted Nieto and Moore on several occasions. Once completed, the application was then forwarded to the underwriting department.
for review.\textsuperscript{404} After once again confirming the information regarding the last doctor visit, the application was underwritten.\textsuperscript{405}

To properly evaluate applicants for this (and other) individual health plans, Blue Shield relies on the detailed information contained in the application regarding past and current health problems, treating doctors, medication, and recommended treatment.\textsuperscript{406} Blue Shield reviews medical and pharmacy records when a condition is disclosed, but it will not routinely obtain such information in order to determine the truthfulness of the application responses.\textsuperscript{407} The underwriter also reviews the company’s internal database to determine if the applicants had any prior claim history.\textsuperscript{408} Here, they did not.\textsuperscript{409}

The underwriter sought additional information from Nieto regarding her last doctor’s visit and Moore regarding his bulging disc and chiropractic visits.\textsuperscript{410} Moore responded by stating that these application responses were made in error, i.e., that he had not visited a chiropractor in over six years and had no current back problems.\textsuperscript{411} Blue Shield, utilizing this information together with its proprietary written guidelines, approved the application\textsuperscript{412} and, effective July 1, 2005, issued a health insurance policy to Nieto and Moore.\textsuperscript{413}

Soon thereafter, Nieto was diagnosed with necrosis of the hip and scheduled for hip replacement surgery on November 10, 2005.\textsuperscript{414} Blue Shield was notified, and its underwriting investigation unit opened a file,\textsuperscript{415} obtaining Nieto’s medical and pharmacy records.\textsuperscript{416} Only then did Blue Shield learn that immediately preceding her application, Nieto received extensive treatment for back and hip pain and had been prescribed multiple medications.\textsuperscript{417} She had visited a chiropractor periodically between 1996 and 2002.\textsuperscript{418} She also saw him seventeen times between February and May 2005 for lower back and hip pain.\textsuperscript{419} Nieto also saw Dr. M. Nation, an
orthopedist, several times between January 2002 and May 2005 for back pain. In 2005, Dr. Nation also treated her for hip pain, which included steroid injections and an oral steroid along with other medications. Nieto continued to complain of pain. Dr. Nation wrote a prescription stating that she was being treated for “severe leg and back pain,” and the doctor requested that Nieto be excused from work “when pain is severe.” Her prescriptions between spring 2004 and spring 2005 included at least four different medications in addition to the steroid treatments.

Blue Shield reviewed this medical information and determined that had this information been disclosed on the application, it would have either declined to issue the policy or would have at least waited to issue coverage until this medical information could be reviewed. Accordingly, on November 16, 2005, coverage was rescinded.

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 California Unfair Competition Law, California Business and Professions Code § 17200. She alleged that the rescission constituted unlawful post-claims underwriting in violation of California Insurance Code § 10384 and was an unreasonable use of her application in violation of Insurance Code § 10381.5. Nieto sought

420. Id. at 910.
421. Id.
422. Id. at 910–11.
423. Id. at 911.
424. Id. at 913.
425. Id.
426. Id.
427. Id.
428. Id. California Insurance Code § 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.” Cal. Ins. Code § 10381.5 (2005).

Nieto argued in addition to the illegal post-claim underwriting claim that even if the undisputed facts established that 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 California Insurance Code §§ 10133 and 10381.5. Reviewing this section and Nieto’s arguments, the trial and appellate courts 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. 103 Cal. Rptr. 3d at 918–19. Nieto relied on Ticconi v. Blue Shield of California Life & Health Insurance Co., 72 Cal. Rptr. 3d 888 (Ct. App. 2008), “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.” The Ticconi court reached its conclusion by construing California Insurance Code §§ 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.” 72 Cal. Rptr. 3d at 902. But here in Nieto, the appellate court affirmed the decision of the trial
compensatory and punitive damages as well as declaratory and injunctive relief. Blue Shield answered and counterclaimed against Nieto seeking a declaratory judgment that it had a right to rescind coverage based on Nieto’s materially false representations and omitted material medical information in her application. Blue Shield sought, and ultimately obtained, an order of summary judgment. The trial court judge ruled that the evidence presented by Blue Shield established that Nieto’s materially false representations and omissions in the application constituted fraud or deceit in that Nieto knew or exhibited a reckless disregard for the truth and acted with the intent of inducing Blue Shield to rely thereon.

Blue Shield satisfied all the requirements necessary to support rescission. California law permits rescission even when the insured’s failure to disclose information is negligent or inadvertent. Here, the evidence was overwhelming regarding the insured’s omissions. Nieto’s argument that she “did not intend to defraud Blue Shield” is thus immaterial and did not create a triable issue of fact. In addition, Blue Shield established the materiality of Nieto’s misrepresentations and omissions because had it known the true facts, it would not have issued the policy.

The trial judge rejected Nieto’s argument that Blue Shield’s conduct constituted post-claim underwriting contrary to Insurance Code § 10384. To the contrary, Blue Shield properly underwrote the application and resolved all reasonable questions arising from the information provided by

court that these sections did not preclude rescission based on fraud and deceit. The court noted that California Insurance Code § 10133 only applied “in the absence of fraud.” 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.

429. 103 Cal. Rptr. 3d at 923.
430. Id.
431. Id. at 913–14.
432. Id. at 914. The issue of Nieto’s intent to deceive Blue Shield was not relevant to Blue Shield’s ability to rescind coverage because intent is not required in California. Id. at 921. Nieto’s intent was important for Blue Shield to defend against her second argument that Blue Shield could not use her application misrepresentations to rescind because the application was not attached to or endorsed on the policy. See supra note 428.

433. Id.
434. Id. at 919–20.
435. Id. at 914, 920.
436. Id. at 920–21.
437. Id. at 920.
438. Id. at 914.
Nieto and Moore.\textsuperscript{439} Blue Shield had no obligation to seek out additional information because the application did not reveal any indication that the information contained therein was false.\textsuperscript{440} Even if Blue Shield had contacted the doctor listed on the application, it would not have learned about Nieto’s extensive orthopedic and chiropractic care.\textsuperscript{441} Nieto did not disclose the identities of her orthopedic or chiropractic physicians.\textsuperscript{442} “Thus, the rescission was not due to (i.e., the result of) any claimed underwriting deficiency.”\textsuperscript{443} Finally, the judge rejected Nieto’s argument that Blue Shield’s failure to attach or enforce the application to the policy prevented rescission.\textsuperscript{444}

The California Court of Appeal affirmed the trial judge’s decision in all respects.\textsuperscript{445} The court agreed that the undisputed evidence supported the finding that Nieto had committed fraud by making material misrepresentations or omissions concerning her health history to Blue Shield before it issued the policy.\textsuperscript{446} In support of its decision, the court cited Insurance Code § 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.\textsuperscript{447} The court also added that summary judgment was equally proper on the ground of misrepresentation, citing Insurance Code § 359, which permits the injured party to rescind a contract of insurance based on a material false representation.\textsuperscript{448} The court noted that Nieto had represented that her last doctor’s visit was three years prior to submitting her application when she actually had seen one physician seventeen times between February and May 2005, including on the day she signed the application.\textsuperscript{449} She had also received ten prescriptions for four medications and also received steroid injections.\textsuperscript{450}

The appellate court affirmed the trial court’s finding that Blue Shield had not engaged in post-claims underwriting in violation of Insurance Code § 10384.\textsuperscript{451} The undisputed facts established that Blue Shield properly completed underwriting and resolved all reasonable questions arising

\textsuperscript{439} Id.
\textsuperscript{440} Id.
\textsuperscript{441} Id. at 914, 927.
\textsuperscript{442} Id. at 927.
\textsuperscript{443} Id. at 925.
\textsuperscript{444} Id. at 914, 918–19.
\textsuperscript{445} Id. at 921, 928.
\textsuperscript{446} Id. at 918–19.
\textsuperscript{447} Id. at 919.
\textsuperscript{448} Id. at 923.
\textsuperscript{449} Id. at 920.
\textsuperscript{450} Id.
\textsuperscript{451} Id. at 927.
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 health care providers listed on the application, Nieto did not list the doctors who had treated her for the conditions that led to the rescission.

Relying on Hailey, Nieto asserted that there were triable issues of fact concerning whether Blue Shield reasonably completed medical underwriting prior to issuing coverage. Hailey, however, involved an interpretation of California Health & Safety Code § 1389.3, which is exclusively applicable and limited to prepaid health care service plans licensed under the Knox-Keene Health Care Service Plan Act and prohibits these plans from engaging in post-claims underwriting. The statute is phrased similarly to § 10384 but does not apply upon a showing of willful misrepresentation.

The California Court of Appeal concluded that even if it were to apply Hailey to the evidence offered in support of summary judgment, the result would be the same. 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 database and confirmed that Nieto had no prior claims history. The court also said that Nieto had provided no evidence that the rescission resulted from Blue Shield’s failure to complete medical underwriting. Thus, there was “no evidence indicating that Blue Shield’s rescission was ‘due to’ its failure to complete the medical underwriting process and resolve all reasonable questions arising from written information submitted in connection with the application prior to issuing the policy.”

This decision provides that health insurance companies may rely on information in the application if the information provided does not raise any issues concerning the health condition or history of the applicant. An insurer does not commit post-claims underwriting if it makes reasonable inquiries of the applicant regarding issues that arise from information con-
tained in the application and by reviewing its internal files for any existing claim or health history prior to issuing coverage.

VI. ANALYSIS OF POST-CLAIM UNDERWRITING

Unfortunately, the continuing controversy surrounding the practice of post-claim underwriting has obscured the fundamental duty of policyholders to provide truthful and complete information on insurance applications. The rule that insurers have a general right to rely on an applicant’s representations is derived from the long-standing insurance principle that it is the applicant’s duty to carefully review the application and accurately disclose those facts that are known because the insurer has a right to know what the applicant knows about the state of his or her health. The insurer’s obligation to follow up on that information is triggered only when there is an indication of need, i.e., the representations cannot be relied on or the statements raise reasonable questions that require further inquiry.

Claimants, ignoring these long-standing and fundamental principles of insurance law, challenge the post-issuance investigation on the basis that if the insurer wants to investigate an insured’s application responses, it should conduct a complete and thorough investigation prior to accepting the individual as an insured. Thus, if an insured denies having any preexisting medical conditions, the insurer must still investigate to determine whether these representations are correct.

For underwriting to be effective, insurers and their applicants must have the same information. Thus, applicants are under a duty of good faith to be complete and truthful in providing their known health history in response to specific questions in the application. It does not matter how

---


466. Casey ex rel. Casey v. Old Line Life Ins. Co., 996 F. Supp. 939, 944 (N.D. Cal. 1998). The insured’s responsibilities to the insurer are not the same. The California Supreme Court’s opinion in Kransco v. American Empire Surplus Lines Insurance Co., 2 P.3d 1 (Cal. 2000), still is the leading case in this regard. There, the court limited the insured’s responsibilities to its
the applicant personally evaluates his or her condition because the insurer is not seeking the applicant’s opinion but only a truthful statement of his or her medical history in response to the questions asked. If an insurer later learns that the insured misrepresented or omitted material information requested by the application and known to the insured, the insurer may rescind the policy as never having been properly formed.

If an insurer is unable to rely upon the assertions made on a policy application before issuing coverage, the application itself will be rendered essentially meaningless. Practically, the rule should not be otherwise. It would be prohibitively burdensome and time-consuming, as well as wholly unnecessary, to impose an obligation on insurers to check or verify all responses contained in the application. Rather, insurers would effectively be required to ignore the policy application, thus treating the insured as a liar, and undertake a

The insurer that had breached the covenant of good faith and fair dealing by failing to settle a third-party action within policy limits raised the insured's comparative bad faith as an affirmative defense, contending that the insured's misconduct contributed to the excess verdict. The court, however, held that an insured's comparative bad faith may not be asserted as an affirmative defense in this situation. A policyholder's action for bad faith against an insurer is a tort, but the insurer's claim for bad faith against the insured is only for breach of contract. The unequal bargaining power between the insurer and insured supports this distinction.

"To be sure, the 'duty of good faith and fair dealing in an insurance policy is a two-way street, running from the insured to his insurer as well as vice versa.' But the scope of the insured's duty of good faith and fair dealing, and the remedies available to the insurer for a breach of the duty, are fundamentally and conceptually distinct from the insurer's reciprocal duty, and the remedies available to the insured for breach of that duty under the insured policy. As this court has explained, it is an insurer's breach of the covenant of good faith that is governed by tort principles, at least as it concerns the availability of tort damages. In contrast, an insured's breach of the covenant is not a tort. An insurer's tort liability is predicated upon special factors inapplicable to the insured." It appears that Kransco applies to first-party insurance as well. Hale v. Provident Life & Ass. Ins. Co., Nos. A092548, A092833, 2003 WL 1510463, at *26 (C.D. Cal. Mar. 25, 2003). This does not, however, remove the insured's obligation to deal with his or her insurance company truthfully on an application, regardless of whether the insured thought the facts in question were material. Pope v. Mercury Indem. Co. of Ga., 677 S.E.2d 693, 698 (Ga. Ct. App. 2009). No case has cited this disparity in obligations to prevent the insurer's ability to conduct a post-claim investigation regarding the insured's eligibility for coverage.


detailed investigation into not only the medical history of the insurance applicant but any fact regarding the applicant that could be at all relevant to the underwriting decision. In other words, an insurer must assume there is deception on the part of the applicant until proven to the contrary.

This unwarranted requirement is unworkable and not in the best interest of the insured or insurer. It will not only delay any underwriting decision by weeks, or even months, but also significantly increase premiums due to the additional staffing requirements to meet this increased workload. In addition, what about doctor, clinic, and hospital time and expense needed to search for and produce these requested records? Nor can insurers control how quickly doctors or the hospitals will respond to requests for medical records. The end result would be a substantial increase in costs to the insurer and a significant delay in the processing of insurance applications.\(^470\) Neither result would be acceptable to consumers or regulators. Such drastic steps would be avoided if courts simply continue to recognize and apply the long-standing rule that policies may be rescinded for material misrepresentations or omissions.

Nor should policyholders be permitted to profit from such misrepresentations simply because the insurer failed to perform an independent investigation before issuing a policy. Rather, just as courts have been willing to impose significant penalties on insurers for dishonest conduct, courts should also recognize that the dishonesty of policyholders has consequences. Courts should rigorously apply a duty of good faith and fair dealing to the policyholder in completing insurance applications. Just as the policyholder should be able to assume that the insurer is acting fairly and honestly, the insurer should be justified in having the same expectations from its policyholders. Individuals too often try to “game” the system by not disclosing correct medical information in order to obtain coverage. They should not be rewarded for such conduct. In this sense, the post-claim investigation of omissions and misrepresentations in a policy application, when performed in good faith, should not be looked at as a means of simply achieving cost

\(^470\) Critics of post-claim investigation argue that the insurer easily could have obtained medical records prior to accepting the application. For example, in Hailey, 69 Cal. Rptr. 3d 789, the court noted that “Blue Shield also might have determined a problem existed had it contacted the Haileys’ primary care physician or previous health insurer. Indeed, the Haileys executed a release authorizing Blue Shield to obtain their medical information . . . as part of the application. Blue Shield apparently had no difficulty using this release to obtain [Mr. Hailey’s] records after he filed his initial claim.” Id. at 801. This argument fails to acknowledge that if a health care service provider or insurer is required to conduct such a preissue investigation for every applicant, millions of such investigations will be necessary, bringing the life and health insurance industry, as well as medical records departments at the various health care providers, to a standstill. See supra note 125 for an illustration of how many policies will be affected by such a rule.
savings but should be recognized as a way of preventing policyholders from unfairly profiting from their own dishonesty.

The general rule nationwide balances the underwriting obligations of the insurer to fully evaluate applicant disclosures and conduct further inquiries when on notice of potential questions or issues with the obligations of the insured, which include the duty of good faith to carefully complete the application and fully disclose all that is known in response to the questions asked. The prudent insurer will not lose sight of the traditional sequence of underwriting, which affords the insurer with the ability to assess properly the risk it agrees to assume while simultaneously protecting the insured’s reasonable expectations of coverage. To that end, the application should succinctly and sufficiently seek information from the proposed insured concerning those specific risks. An insurer already faces an uphill battle in rescinding a policy when it chooses to forgo the risk assessment prior to issuing coverage only to learn subsequently that the risk would not have been accepted had all the information been known. The complete evaluation approach will afford adequate protection to both the insurer and the proposed insured.

VII. CONCLUSION

The doctrine of insurance bad faith is premised upon contract law’s positive corollary of good faith and fair dealing. Many state court decisions and statutes permit an insurer to rescind coverage for material misrepresentations contained in an application for life or health insurance. This includes the post-issuance investigation to identify those individuals who failed to properly disclose preexisting medical or other conditions that prevented the insurer from accurately assessing the risk it was asked to assume. Traditionally, insurers have been entitled to rely on applicants’ representations regarding their health histories when properly completing their underwriting obligations unless there is reason to suspect the truth or accuracy of that information.

As long as insureds continue to make material misrepresentations to either obtain benefits to which they would not be entitled or to obtain benefits at a lower premium rate, a charge of bad faith cannot stand because insurers will have a reasonable basis to challenge the availability of coverage. To find otherwise would condone insurance fraud. The few courts that have challenged post-claim underwriting in its “true” form (an insurer’s failure to look beyond the application) have simply ignored fundamental principles of insurance law permitting insurers to conduct post-claim investigations as long as they occur within the applicable contestable time period and the insurer was not otherwise on notice of discrepancies contained in the application.