

STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
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Sacramento, CA 95814

DRAFT
FINAL STATEMENT OF REASONS

June 4, 2010

REG-2007-00054

Standards for Health History Questionnaires in Health Insurance Applications, Pre-Issuance Medical Underwriting Requirements; Rescission of Health Insurance Policies and Agent Attestation Requirements Regarding Assistance with Submission of Health Insurance Applications

UPDATE TO THE INFORMATIVE DIGEST

Since June 5, 2009, two significant changes in applicable law affecting the proposed regulations have occurred, and are discussed below. They are: 1) the enactment of federal health care reform law, specifically, the Patient Protection and Affordable Care Act (hereinafter “ the Act”) on March 23, 2010 and 2) the decision in *Nieto v. Blue Shield of California Life and Health Insurance Company (2010)*, 181 Cal. App. 4th 60 . The decision is the first published California appellate case to apply Insurance Code § 10384 which prohibits postclaims underwriting and is the primary statute being implemented by these regulations. The petition for review was denied by the California Supreme Court.

SECTION 2712 OF THE FEDERAL PUBLIC HEALTH SERVICE ACT

On page 4 of the Informative Digest originally published on June 5, 2009 then-existing case law that governed the standard of proof regarding an applicant’s state of mind when answering health history questions and which applied to insurers seeking to rescind a health insurance contract was cited as *Thompson v. Occidental Life Insurance Company (1973)* 9 Cal. 3d. 904. On March 23, 2010, Section 2712 ¹ was added to the federal Public Health Service Act. This Section takes effect on September 23, 2010 and will override both the standard set by *Thompson* and the requirements of Ca. Ins. Code § 10380² in health insurance rescission cases.

¹ Section 2712 of the Federal Public Health Service Act “ A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee and only as permitted under Section 2702 (c) or 2742(b).”

² The falsity of any statement in the application for any policy covered by this chapter shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

In response to the federal enactment of Section 2712 of the “Act”, the Department amended the proposed regulations by deleting all references to the *Thompson* case and the standard set by this case. Specifically, the Department struck the last sentence of Section 2274.78(c) which cited the Thompson standard with respect to the applicant’s alleged misrepresentation of material health information on the health insurance application imposed on an insurer seeking to rescind a health insurance contract.

There is no need to update any of the information contained in the Informative Digest for this matter.

UPDATE OF INFORMATION CONTAINED IN INITIAL STATEMENT OF REASONS

On April 19, 2010 the Department issued a Notice of Availability of Revised Text and invited comments from the public on the Amended Text of the Regulation until May 4, 2010 at 5:00 p.m. Following discussion of the *Nieto* case, each of the changes made in the Amended Text of the Regulation is explained below.

Nieto v. Blue Shield of California Life and Health Insurance Company (2010) 181 Cal. App 4th 60

A few of the public comments offered interpretations of the *Nieto* case and projected the effect of this case on the regulations. Specific responses to those comments are contained in the Summary of Responses section of this Final Statement of Reasons. Commenters speculate on the future impact of the *Nieto* ruling and findings on yet to be litigated rescission cases. The Department respectfully disagrees with the commenter’s hoped-for extension of *Nieto* to other, likely different fact patterns and evidentiary findings. The Department acknowledges the *Nieto* case, analyzes it and finds that it has no impact on the regulations proposed.

Procedural History and Trial Court Findings

The trial court in *Nieto* ruled in July 2008 that Blue Shield Life (BSL) was entitled to rescind Nieto’s health insurance contract due to the insured’s fraud but required BSL to file a separate statement establishing the material undisputed facts with respect to each element of fraud. BSL did so and prevailed on summary judgment in November 2008. In granting BSL’s motion, the trial court determined that each element of fraud had been proven by undisputed material facts produced during various pre-trial motions. The trial court then proceeded to apply various Insurance Code statutes and cases that had some factual or legal overlap with *Nieto*.

Application of Insurance Code Sections 10113, 10381.5 and 10384

Even though the trial court stated that as a matter of law, BSL was entitled to rescind coverage if the undisputed evidence showed that Nieto committed fraud by making material misrepresentations or omissions concerning her medical history or condition to BSL before it issued the policy, it proceeded to apply the Insurance Code statutes that require BSL to demonstrate that it had completed its medical underwriting and resolved reasonable questions arising from the application. The trial court, with the appellate court’s concurrence, did not

conclude its analysis with the ruling that BSL's rescission was justified based on the undisputed material facts. Significantly, it proceeded to apply all three of the key rescission statutes: 10113, 10381.5 and 10384 even after it had made a finding that the insured's fraud otherwise justified the rescission.

The court found that Insurance Code Sections 10113 and 10381.5 did not bar rescission in this case based on the legislative history of Section 10381.5 and its linkage to Section 10113. The trial court relied on the legislative history of Section 10381.5 which it observed was "designed to 'repeat' a provision of section 10113.... and separately established that when a copy of the application is neither attached to nor endorsed on the policy the insured is not bound by any statement in the application." The trial court, with appellate concurrence, proceeded to find that 10381.5 and 10113 in combination would not bar rescission as these statutes apply only "in the absence of fraud."³ Since the trial court, with appellate concurrence, found that the undisputed material facts supported a finding of fraud, the attachment provisions of the Insurance Code did not stop the rescission from passing legal muster. In addition, the court emphasized its duty to harmonize the various insurance code statutes and "adjust the equities."

Significantly, the court did not ignore the Insurance Code sections 10113 and 10381.5 requiring that the application for the policy be attached to or endorsed on at the time of delivery; rather it expressly applied the specific unique facts of the Nieto case, where a finding of fraud was made, to determine that the lack of attachment did not bar the rescission. The Nieto court did not eliminate the statutory requirement that, in the absence of fraud, a health insurer must attach to or endorse on the application to the policy at the time of delivery if the insurer wishes to rely on statements made in the application for any reason, including rescission.

Application of Insurance Code Section 10384

Similarly, the trial court in Nieto, with appellate concurrence, applied the underwriting requirements of Ins. Code § 10384 in spite of the fact that it had already made a finding of fraud by the insured. The trial court reviewed the factual evidence offered by BSL demonstrating that it had completed its medical underwriting before issuing the policy and that it had resolved all

³ Ca. Ins.Code section **10113**. Every policy of life, disability, or life and disability **insurance** issued or delivered within this State on or after the first day of January, 1936, by any insurer doing such business within this State shall contain and be deemed to constitute the entire contract between the parties and nothing shall be incorporated therein by reference to any constitution, by-laws, rules, application or other writings, of either of the parties thereto or of any other person, unless the same are indorsed upon or attached to the policy; and all statements purporting to be made by the insured shall, **in the absence of fraud**, be representations and not warranties. Any waiver of the provisions of this section shall be void.

Ca. Ins. Code Section 10381.5. 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 as a part thereof.

reasonable questions arising from the written information submitted on or with respect to Nieto's application. The trial court cited factual evidence about the follow up questions that BSL had asked of the applicants because the application was incomplete, that BSL checked its own claims database for prior claims and reached out to seek clarification from the co-applicant about doctor visits. The court found sufficient evidence to make a finding that BSL did not engage in prohibited postclaims underwriting. Thus, the fact that the court applied the postclaims underwriting statute even with the finding of fraud demonstrates that the Insurance Code's duty to complete medical underwriting obtains even if fraud in the inducement is proven.

The *Nieto* court applied a narrow reading of the statute's requirements to complete medical underwriting and *under this specific set of unique facts surrounding the omissions by the applicant* and the lack of information available to BSL to underwrite, it found that BSL had not engaged in prohibited postclaims underwriting. Each postclaims underwriting case will necessarily involve a different set of facts surrounding the types of underwriting activities completed by the insurer, the types of material omissions or statements made or not made by the applicant, and other facts. It is precisely because of the heavily fact-driven nature of rescission cases that the proposed regulations are so important to consumers and the industry. The statutory language of Insurance Code § 10384 is very broad and is especially in need of further interpretation of what constitutes completion of medical underwriting under the statute. Even though the *Nieto* court observed in this specific situation that BSL did not have a duty to seek out the applicant's omitted doctors, a slightly different fact pattern could lead a court to find prohibited postclaims underwriting.

Since the trial court, with the appellate court's concurrence, applied the relevant Insurance Code statutes even in making a finding of fraud by the applicant, the *Nieto* case is not in conflict with the regulations.

Explanation of Changes in Amended Text of Regulation

On April 19, 2010, the Department issued a Notice of Availability of Revisions to Text of Regulations. The Department review comments to the Revised Text and comments to the original text and made some changes in response.

Safe Harbor and Changes to Section 2274.71 (b)

Certain commenters objected to the lack of a safe harbor provision in Section 2274.71(b) and specifically requested that the Department create one for health insurers who purport to comply with the regulations. The Department declined to create such a safe harbor and is not legally required to do so. However, in the interest of clarifying that the Department is interested in encouraging the use of new underwriting methods or techniques that it expects to become available with the advent of improved Health Information Technology(HIT), the text was amended to add a new sentence at the end of Section 2274.71(b) “ This article does not preclude the insurer's use of new underwriting methods of techniques.”

The Department struck the prior sentence (~~This article also is not intended to set forth an exhaustive list of acts or practices necessary to comply with applicable laws~~) to avoid confusion

about what it will take to prove compliance with the regulations. Elimination of this sentence leaves determination of compliance issues to the future where health insurers are expected to employ more sophisticated underwriting techniques using new HIT applications.

Impact of Federal Law in the Future

On March 23, 2010, the Congress enacted one of the most far-reaching pieces of legislation in recent decades, commonly known as the federal health care reform bill, the Patient Protection and Affordable Care Act of 2010, 111 Pub. L. No. 48, 124 Stat. 119 (2010). In response to comments and on its own initiative, the Department added Section 2274.71(c) to clarify that in the event that any part of federal law, including future regulations not yet issued or future amendments, should specifically conflict with and override any specific provision of the regulations, the remaining provisions which do not conflict and are not overridden will survive. This savings clause is intended to address future possibilities that are difficult to predict at this time. It is unlikely that any future federal laws or regulations will address underwriting requirements however.

Changes to the Note for each Section

The Department eliminated reference to the *Thompson v. Occidental Life Ins. Co.* 9 Cal 3d 904 (1973) in each Note since the standard in the *Thompson* case has been replaced by Section 2712 of the “Act”. See discussion above.

The Department eliminated reference to the *Ticconi v. Blue Shield of California Life and Health Ins. Co.*, 160 Cal. App. 4th 528 (2008) after determining that it was not necessary to support the Department’s interpretation of the requirements of Sections 10113 and 10381.5.

On December 21, 2007 the Department issued a Notice of Amendment to Text of Regulation. A public comment received in response to the originally noticed text of regulations had indicated the presence of a potential clarity problem in the definition of the term “side fund” in Section 2695.24 of the proposed regulations. Accordingly the Department amended the regulations to eliminate the possibility that the definition might be misunderstood in the way it apparently had been. Additionally, the Department took the opportunity to remedy two other potential clarity problems present in the originally noticed Text of Regulations. Each of these arguably substantive changes were made to subdivision (n) of Section 2695.24.

Nonsubstantive changes have also been made to the regulation text. As indicated in the Amended Text of Regulation, we have inserted into Paragraph (e)4 of Section 2695.26 a parenthetical citation to the Act which will allow the document to be located more readily by means of electronic legal research software. The following nonsubstantive changes were not indicated in the Amended Text of Regulation: In Subdivision (c) of Section 2695.23 we have changed the word “subsection” to “subdivision” and now refer to the subdivision using its complete designation (as “subdivision (c)”) the first, instead of the second, time the subdivision

is referenced; we have deleted a colon that was not indicated as deleted in the Amended Text of Regulation, immediately preceding Paragraph (n)1 of Section 2695.24; and into Subdivision (o) of Section 2695.24 we have inserted the word “appointment,” which was present in the model regulation but was inadvertently omitted from both the originally noticed Text of Regulation and the Amended Text of Regulation.

UPDATE OF MATERIAL RELIED UPON

No material other than public comments, the transcript of the public hearing, the Notice of Availability of Revised Text, the Amended Text of Regulation, the declaration of mailing therefore and this Final Statement of Reasons has been added to the rulemaking file since the time the rulemaking record was opened, and no additional material has been relied upon.

MANDATE UPON LOCAL AGENCIES AND SCHOOL DISTRICTS

The Department has determined that the proposed regulations will not impose a mandate upon local agencies or school districts.

ALTERNATIVES

The Commissioner has determined that there are no alternatives that would be more effective, or as effective and less burdensome to affected persons, than the proposed regulations. In support of this determination is the fact that no such alternatives were suggested during the public comment period, despite the express invitation therefor that was extended in the Notice of Proposed Action.

