



presents

Insurance Rescission and Exclusions

Resolving Coverage Disputes Arising From Prior Knowledge and Misrepresentation Allegations

A Live 90-Minute Teleconference/Webinar with Interactive Q&A

Today's panel features:

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Wednesday, February 3, 2010

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INSURANCE RESCISSION: THE ROLE OF STATUTES AND THE FLORIDA EXAMPLE

by

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Resolving Coverage Disputes Arising From Prior Knowledge and Misrepresentation Allegations

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Resolving Coverage Disputes Arising From Prior Knowledge and
Misrepresentation Allegations

STRAFFORD PUBLICATIONS WEBINAR

Wed., February 3, 2010

State Law Remedy Availability, Now.

- Hearing of the U.S. House of Representatives Subcommittee on Oversight and Investigations, June 16, 2009.
- Three Health Insurance Company Executives were asked: Would your Companies limit Rescission to Intentional Misrepresentations in Applications?
- “No” x all 3.

Why did they all say, “No” to that question?

- The answer is why we are here.

The Statutes: Florida Statute Section 627.409's Example

(1) Any statement or description made by or on behalf of an insured ... in an application, or in negotiations for a policy or contract, is a representation and is not a warranty.

The Florida Statutory Example Continued

- “statement or description”

And

- “made by or on behalf of an insured”

IS

- “a representation”

Subsection (1) of Fla.
Stat. § 627.409 (2009),
continued

- “A misrepresentation, omission, concealment of fact, or incorrect statement may prevent recovery under the contract or policy only if any of the following apply:

What exactly “may prevent recovery”?

- “a misrepresentation”
- Probably a fraud standard.
- Florida like some other jurisdictions: Cause of Action exists for “negligent misrepresentation”.

What else “may prevent recovery”?

- *An “omission”*
- *Plain and ordinary meaning.*
- *The documents need to ask for it before it is an “omission”.*

Also:

A “concealment of fact”.

- Does this add anything to a fraud or misrepresentation standard to succeed on the claim of misrepresentation in the application?
- Does it add anything to the Burden of Proof?

“Last but not least ...”

- *An “incorrect statement”.*
- See how this ties in when we address “materiality” either to acceptance of the risk or to the hazard assumed by the insurance company.

What result can we expect?

- *Not certainty.*
- “*may* prevent recovery under the contract or policy” [Emphasis added.]

Is there any certainty here?

- Yes.
- “*only* if any of the following apply:”

Fla. Stat. § 627.409(1) (2009).

[Emphasis added.]

How do the facts combine with the legal standard to prove or defend a Statutory Rescission Claim?

- *Apply the law to these facts:*
“The misrepresentation, omission, concealment, or statement”
- *Apply this law to those facts:*
“is fraudulent or is material”.

Fla. Stat. § 627.409(1)(a) (2009).

Track the Statutory Requirements! There may be a Disconnect in your Client's favor.

- “The misrepresentation, omission, concealment, or statement”.
- This language found in Subsection (1)(a) *basically* tracks the language found in Subsection (1) which we looked at earlier.
- However: “concealment *of fact*”

And

- An “*incorrect* statement”.
- Statutes providing Claims for Rescission based on alleged misrepresentation in an Insurance Application will not always be symmetrical. *The Statutory Disconnects can affect the outcome of your Client's Case.*

Breaking down the legal standards established in the Statute: Part One.

- “is fraudulent”.
- Seems straightforward, and probably is.
- Except: Not every jurisdiction’s “fraudulent” includes “negligent misrepresentation”.
- Some do: Such as Florida, as we have already seen.

Breaking down the Statutory Legal Standards: Part Two.

*“or is material either to the
acceptance of the risk or
to the hazard assumed by
the insurer.”*

Fla. Stat. § 627.409(1)(a) (2009).

[Emphasis added.]

- **BURDEN OF PROOF.**

“MATERIAL,” Yes, but material to what?

- “either ... or”.
- First: “either to the acceptance of the risk”
- How to prove?
- Sources of Testimony: Ex.: Underwriters.
- Sources of Other Evidence: Ex.: Previously Written Underwriting Manuals.

“MATERIAL” to what else?

- “or to the hazard assumed by the insurer.”
- Proof any different?
- Standard any different?

The same or more detailed “Materiality” standards?

- *Florida Courts for one example.*
- *An overall requirement for each aspect of “materiality”:*

If the true facts had been known to the insurer pursuant to a policy requirement or other requirement

- *“policy requirement”.*
- *“or other requirement”.*

Such as? What YOU argue in a given case. Largely open question.

PARENTHETICALLY

...

- In Florida as in many jurisdictions, the Rescission Statute generally trumps ‘contrary’ Insurance Policy or Application language.
- *Exception: When the Application calls for “true to best of knowledge and belief”.*

Parenthetically, continued ...

- This may be one of the reasons for the 3 x “No” answers of the Health Insurance Company executives at the Congressional Hearing on June 16, 2009.

An overall requirement
which has unexplored
potential for
practitioners.

“the insurer in good faith”
would or would not have
done certain things.

“In Good Faith” Explored: One of Two.

- Statutory “Unfair Methods of Competition and Unfair or Deceptive Acts or Practices”:
- Ex.: KNOWING “false statements and entries,” Fla. Stat. § 626.9541(1)(e), or
- Ex.: KNOWING “misrepresentation in insurance applications.” Fla. Stat. § 626.9541(1)(k).
- Court holdings – Overwhelming majority hold *administrative* violations, enforceable across the country by “Departments of Insurance”.
- But – “evidence?”

Actionable “Unfair Claim Settlement Practices”

- Fla. Stat. § 626.9541(1)(i)1 (2009):
Attempting to settle claims on the basis of an application, when serving as a binder or intended to become part of the policy, or any other material document *which was altered without notice to, or knowledge or consent of, the insured.*
[Emphasis added.]
- Made actionable by “Florida Bad Faith Statute,” Fla. Stat. § 624.155(1)(a)1 (2009).

First of Four subject to
“the insurer in good
faith:”

“would not have issued the
policy or contract”

- Proof: Testimony of Underwriters.
- Proof: Testimony of Agents’
Experiences with this Insurance
Company, where admissible.
- Other Evidence, redacted: Past
Similar Applications Declined.

Second of Four: “the insurer in good faith:”

“would not have issued it [the policy or contract] at the same premium rate”

- Underwriters, once more.
- Agents, to establish pattern or practice where admissible.
- Evidence redacted: Past Similar Policy Premiums Charged.

Third of Four: “the insurer in good faith:”

“would not have issued a policy
or contract in as large an
amount”

- Same considerations of proof.
- The estimated/evaluated extent of “the risk,” “the hazard” involved.

Fourth of Four: “the insurer in good faith:”

“or would not have provided coverage with respect to the hazard resulting in the loss.”

- Again, same considerations of proof, and:
- Again, estimate/evaluation of the risk or the hazard to be assumed.

“Insured’s” breach of the Insurance Application or the Insurance Policy?

“A breach or violation by the *insured* of *any* warranty, condition, or provision of any wet marine or transportation insurance policy, *contract of insurance, endorsement, or application therefor* does not void the policy or contract, or constitute a defense to a loss thereon, *unless such breach or violation increased the hazard by any means within the control of the insured.*”

Fla. Stat. § 627.409(2) (2009). [Emphasis added.]

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Insurance Rescission and Exclusions

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Discussion Overview

- Coverage Issues
 - Warranty Questions and Prior Knowledge Exclusions
 - Standard Applicable
 - Objective
 - Subjective
 - Subjective/Objective
 - Severability Provisions

Rationale for Prior Knowledge Exclusion

Protects against “Moral Hazard”

Because Claims Made Policies generally are intended to cover Claims first made during the policy period, Insurer needs to be able to protect itself against professionals who recognize their own errors and rush to get coverage before a claim is asserted.

Typical Prior Knowledge Exclusion

Without prejudice to any other rights and remedies of the Underwriter, it is agreed that any claim arising from any fact, circumstance, situation, transaction, event, act, error or omission required to be disclosed in response to Question [#] is excluded from the proposed insurance.

Denying Coverage for Claim vs. Rescinding Policy

- Prior knowledge exclusion operates to bar coverage for Claim but keeps the policy in effect
- Rescission based on a misrepresentation in the policy application will void the entire policy

Determining the Standard

- Common law
 - case law applying either an objective or subjective standard
- Statutory law
 - Statute articulating standard (e.g. addressing intent or materiality of misrepresentation in policy application)
- Policy provisions
 - Exclusion in policy or question on application sets the standard (e.g. “insured had no basis to believe . . .” or “reasonable basis to believe . . .”)

Types of Standards

- Objective Standard
- Subjective Standard
- Two part: Subjective-Objective standard

Objective Standard

- Followed by majority of jurisdictions
- Sample Application Question
 - “Does any lawyer know . . . of any circumstances, acts, errors or omissions that could result in a professional liability claim . . .?”
- Looks at what a reasonable professional knew or should have known
 - Is the statement “objectively false?”
 - Was there a “reasonable basis to believe?”

Objective Standard

Statutory Provision Applied to Rescission Analysis

Misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under the policy or contract unless:

- (1) Fraudulent;
- (2) Material either to the acceptance of the risk or to the hazard assumed by the insurer; or
- (3) The insurer in good faith would either not have issued the policy or would not have issued a policy for the same limits or premium or would not have provided coverage with respect to the hazard resulting in the loss if the true facts had been known to the insurer as required either by the application for the policy or otherwise.

Subjective Standard

- Endorsed by a minority of courts
 - Standard derived from policy language
 - Is the Insured aware of any fact, circumstance or situation which *he has reason to believe* might result in any future claim which would fall within the scope of the proposed insurance?
 - “Judgmental component”
 - Looks at the absence of bad faith on the part of the insured party

Subjective-Objective Standard

- Recent trend in the use of an intermediate standard utilizing a two-prong, subjective-objective test.
 - Two Questions
 - Subjective Standard: whether the insured knew of certain facts; and then
 - Objective Standard: whether such facts could reasonably have been expected to give rise to a claim.

Policy Language Critical

- Some states apply either an objective or a subjective standard depending on the policy language.
 - “reasonableness” language vs. “to the best of his/her knowledge”

Severability Provisions

- Used to protect innocent directors and officers from having their coverage rescinded because of the acts of other Insureds
- Severability provisions are used to protect Insured Persons, i.e. “natural persons” rather than the insured-entity

Severability Provisions

- Relevant considerations
 - “when can the conduct or knowledge of one individual be imputed to other individuals for purposes of excluding or revoking coverage?”
 - “full severability provision”
 - “partial severability”
 - Focus on the signor of the application

Severability Provisions

- Interaction of Severability Provision and Prior Knowledge Exclusion
 - Where provision conflicts with exclusion, may be ambiguity (*Twin City Fire*, Cal. 2005)
 - Policy language can resolve a conflict between an exclusion and a severability provision (*XL Specialty*, SDNY 2009)

RESCISSION: Justified Action or Business Strategy

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Disclaimer

The views expressed by the participants in this program are not those of the participants' employers, their clients, or any other organization. The opinions expressed do not constitute legal advice, or risk management advice. The views discussed are for educational purposes only, and provided only for use during this session.

Rescission – An Overview

- Rescission in general.
- What does it mean for the insurance company?
- What does it mean for the policyholder?

Contrast with Exclusions

- Prior knowledge.
- Policyholder misrepresentations.
- Other common exclusions and policy conditions.

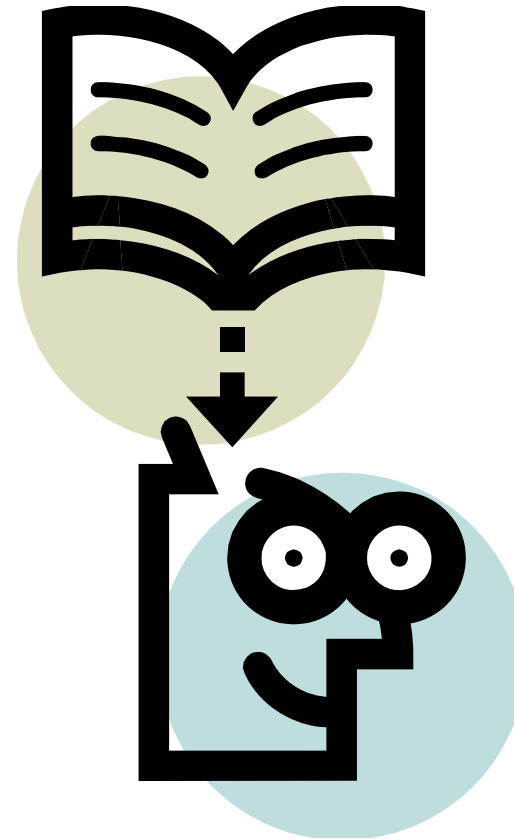
Industry Trends and Noteworthy Items

- Insurance industry trends.
- New insurance products.
- Exclusions.
- PMI.



Private Mortgage Insurance

1. Why did the mortgagee buy PMI in the first place?
2. Whom does PMI benefit?



Turn Back Time

- What information was provided when the insurance policy was purchased?
- What has changed?



Mortgage Crisis & Rescission

- Proliferation of defaults
- Decline in property values
- Proliferation of claims under PMI policies



Q & A

- Compare rescission in the health insurance context to rescissions in other lines: is the same rationale used in all contexts?

What can be done – Policyholder options

- What can be done in terms of measures to protect unwary consumers?
 - Health Insurance?
 - PMI?
 - Other lines of insurance?
- Anything else?

From Insurer Standpoint

- Is rescission a necessary and available avenue?
- Who is really “crying wolf” here?
 - The policyholder, government or insurer?

THANK YOU!

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RESCISSION OR POST-CLAIMS UNDERWRITING?

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INTRODUCTION

Here is how Rescission works in the vast majority of jurisdictions now.

First, Rescission of Insurance Policies is a creature of State, not Federal Law. That would change if the proposed Federal Rescission provision is enacted.

Second, Regulation of Insurance has been almost exclusively left to the States for a long time, not to the Federal Government. Rescission is one of several areas in

which this historical arrangement would change if the proposed provision in the pending Senate Health Care Bill becomes Law.

AN EXAMPLE: THE FLORIDA EXPERIENCE OF HOW RESCISSION WORKS

Florida is a good example of how Rescission works now. Florida Statute Section 627.409 (2009), available online at http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=Ch0627/SEC409.HTM&Title=-%3e2009-%3eCh0627-%3eSection%20409#0627.409, applies to Health Insurance Companies as well as other types of Insurance Companies concerning Claims for Rescission. (Related Claims involving Cancellation and Nonrenewal are beyond the scope of this article at this time.)

In pertinent part, current Rescission Law throughout the United States generally applies to "any statement or description" which is "made by or on behalf of" an applicant for an Insurance Policy. Clearly, the applicant is expressly made responsible for others who make statements or provide descriptions on her, his or its behalf.

If the "statement or description" in the application is [1] a "misrepresentation," [2] an "omission," [3] a "concealment of fact," or [4] "an incorrect statement" then any one of these four categories can "prevent recovery under the contract or policy" if, in pertinent part:

The misrepresentation, omission, concealment, or statement is **fraudulent** or **is material either to the acceptance of the risk or to the hazard assumed by the insurer.**

Fla. Stat. § 627.409(1)(a) (2009), available at http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=Ch0627/SEC409.HTM&Title=-%3e2009-%3eCh0627-%3eSection%20409#0627.409. [Emphasis added.]

OR:

If the true facts had been known to the insurer pursuant to a policy requirement or other requirement, the insurer in good faith would not have issued the policy or contract, would not have issued it at the same premium rate, would not have issued a policy or contract in as large an amount, **or** would not have provided coverage with respect to the hazard resulting in the loss.

Fla. Stat. § 627.409(1)(b) (2009), available online at http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=Ch0627/SEC409.HTM&Title=-%3e2009-%3eCh0627-%3eSection%20409#0627.409.

[Emphasis added.] It may be helpful to break out and list the four factors of "**materiality**" which might support a cause of action for Rescission under State Law ***if in good faith the Insurance Company would have done these things, or in good faith would not have done them as the case may be, AND*** in the event that a misrepresentation, omission, concealment or statement in an application was ***not fraudulent***:

If the true facts had been known to the insurer pursuant to a policy or other requirement, the insurer in good faith:

[a] would not have issued the policy or contract[;]

[b] would not have issued the policy or contract at the same premium rate[;]

[c] would not have issued a policy or contract in as large an amount[;] or

[d] would not have provided coverage with respect to the hazard resulting in the loss.

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"Rescission or Post-Claims Underwriting?"
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In short, as Rescission Law stands now, it purports to include representations, omissions, concealments or statements which are "incorrect" without necessarily also being "fraudulent" so long as they are "material either to the acceptance of the risk or to the hazard assumed by the insurer." Id., available online at http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=Ch0627/SEC409.HTM&Title=-%3e2009-%3eCh0627-%3eSection%20409#0627.409. [Emphasis added.]

In general terms, the non-fraudulent grounds for rescission based on representations, omissions, concealments or statements which are "material" to the risk accepted or to the hazard assumed, have been interpreted by Courts as being defined by the four factors listed as [a] through [d] above.

RESCISSION UNDER THE HEALTH CARE BILL PENDING IN THE U.S.
SENATE

Section 1001 of the Senate Health Care Bill contains an amendment to the Public Health Service Act ("PHSA") which would add a "PROHIBITION ON RESCISSIONS." This provision would come in a new Section 2712 of the PHSA. Available online at <http://documents.nytimes.com/senate-health-care-bill#p=1>, and at http://insuranceclaimsissues.typepad.com/insurance_claims_and_issu/2010/01/senate-health-care-bill-federal-regulation-continues-.html?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+typepad%2Fwalldj%2Finsurance_claims_and_issu+%28Insurance+Claims+And+Issues%29, among other sites, § 1001, at 16-17. The "prohibition on rescissions" would apply to Health Insurers subject to the Bill, limiting their Remedy in cases where they sought Rescission after a person was an insured -- with no mention made of whether the insured had made a Claim, or not. The new national limitation would restrict Rescission in such

cases to circumstances where the "misrepresentation of material fact" was:

(1) **intentional**, thereby eliminating the possibility of "unintentional" misrepresentations of material fact as now available in many jurisdictions under existing Rescission Laws, and

(2) the Health Policy or Plan itself prohibited the "intentional misrepresentation of material fact," **removing the possibility of the Policy or Plan documents remaining silent yet the State's Rescission Laws nonetheless allowing the Health Insurer to avail itself of the Rescission Remedy even though their Policies may be silent.**

The Senate Health Care Bill would restrict the Remedy of Rescission available to "a health insurance issuer offering group or individual health insurance coverage" regarding any "enrollee [insured] once the enrollee is covered under such plan or coverage involved," to:

fraud or ... an **intentional** misrepresentation of material fact as prohibited by the terms of the plan or coverage.

Available online at, among other sites,
http://insuranceclaimsissues.typepad.com/insurance_claims_and_issu/2010/01/senate-health-care-bill-federal-regulation-continues-.html?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+typepad%2Fwalldj%2Finsurance_claims_and_issu+%28Insurance+Claims+And+Issues%29,
at 16-17. [Emphasis added.]

CONCLUSION

These proposed changes to the law governing Rescission of Insurance Policies in the Health Insurance context may be highly desirable. Desirable or not, these are the

proposed changes in the pending Senate Health Care Bill, to the Law of Rescission developed in the States. These proposed changes are in reaction to the existing Law of Rescission. The changes identified in this paper are clearly in reaction to charges that Rescission has been used as a device for "Post-Claims Underwriting," meaning that Insurance Companies allegedly pursue Rescission Remedies after Claims are made on their Insurance Policies, as a way to avoid paying Claims that might otherwise be covered.

The changes to the Law of Rescission identified in this paper would be applied to Health Care Insurance Companies regulated by the pending Senate Health Care Bill if it becomes Law:

1. Elimination of grounds for nonintentional misrepresentation in the application.
2. Elimination of "fraud" or "an intentional misrepresentation of material fact" which are **not** prohibited by the terms of the Group Health Insurance Plan or Policy.
3. Preemption of inconsistent State Laws and Regulations.

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