

Insureds' Health vs. Insurers' Wealth: Bad Faith in the Healthcare Industry

It's finally happened. After all these years of fender-bender and collection cases, someone has walked in your door with what appears to be an ironclad bad faith suit.

He's told you all about how his HMO or disability carrier denied a claim that clearly should have been covered, and he wants you to take on the insurer.

The prospective client hasn't even finished telling you his story, and your head is already dizzy with visions of a seven-figure judgment against a deep-pocket defendant that a jury is sure to despise. But before you spend your share of the recovery, you may want to ask some hard questions about your potential client's case. Does the law currently support lawsuits against HMOs? What theories of recovery can be pursued against a disability carrier? Will you be able to get the case to a jury, or will it be shipped to arbitration (or, worse yet, be preempted by ERISA or Medicare)? And even if you're able to avoid preemption, can the insurer reduce its exposure based on the prospective client's "comparative bad faith"?

This syllabus is designed to help you answer these questions and others like them, and to increase the likelihood that your decision on whether to accept or reject the case will be a good one.

LIABILITY OF HEALTHCARE INSURERS

1. HMOs

Effective January 1, 2001, California Civil Code section 3428 imposes liability against an HMO that fails to furnish covered benefits. Under the statute, an HMO owes its members a duty of ordinary care to arrange for the provision of "medically necessary" health care services as provided under the HMO plan [Civil Code § 3428(a)]. And an HMO is liable for "any and all harm" caused by its breach of that duty where (1) the breach results in the denial, delay or modification of care recommended for, or furnished to, a member¹ and (2) the member suffers "substantial harm"² [Civil Code § 3428(a)]. Moreover, recoverable damages include, but are not limited to, the tort damages set forth in Civil Code § 3333 ("all detriment proximately caused" by the breach of duty), such that emotional distress damages and, presumably, punitive damages may be recovered [see Civil Code § 3428(j)].

But even without Civil Code section 3428, HMOs - like other insurers - have been found liable for insurance bad faith. Indeed, the California Supreme Court has confirmed that any distinction between traditional insurance companies and health care service plans is "immaterial" [Sarchett v. Blue Shield of California (1987) 43 Cal.3d 1, 4, 233 Cal.Rptr. 76, n. 1], and thus that a health care organization can be held liable for breach of the covenant of good faith and fair dealing.³

Other theories available against an HMO include:

Third-party beneficiary of contract between HMO and physician provider group [see Croskey, Kaufman, et al., Cal. Prac. Guide: Insurance Litigation (The Rutter Group 1999), §§ 12:64 and 12.65];

Tortious breach of contract [see Wilson v. Blue Cross of So. Calif. (1990) 222 Cal.App.3d 6604];

Interference with doctor-patient relationship [see Heller v. Norcal Mutual Ins. Co. (1994) 8 Cal.4th 30, 45, 32 Cal.Rptr.2d 200];

Intentional misrepresentation [see Sanchez v. Lindsey Morden Claims Services, Inc. (1999) 72 Cal.App.4th 249, 254, 84 Cal.Rptr.2d 799, 802 and Orient Handel v. United States Fidelity & Guaranty (1987) 192 Cal.App.3d 684, 692-693; 237 Cal.Rptr. 667, 671];

Negligent misrepresentation [see Davis v. Blue Cross of No. Calif. (1979) 25 Cal.3d 418, 428-429, 158 Cal.Rptr. 828, 834 and Westrick v. State Farm Ins. Co. (1982) 137 Cal.App.3d 685, 692, 187 Cal.Rptr. 214, 219];

Breach of fiduciary duty [see Moore v. Regents of the University of California (1990) 51 Cal.3d 120, 128-132];⁵

Intentional infliction of emotional distress [see Fletcher v. Western National Life Ins. Co. (1970) 10 Cal.App.3d 376, 394, 89 Cal.Rptr. 78, 88 and Little v. Stuyvesant Life Ins. Co. (1977) 67 Cal.App.3d 451, 461-462, 136 Cal.Rptr. 653, 659];

RICO [see Dana Corp. v. Blue Cross & Blue Shield (6th Cir. 1990) 900 F.2d 882, 884-885]; and

Business & Professions Code section 17200 [see State Farm Fire & Casualty Company v. Superior Court (Allegro) (1996) 45 Cal.App.4th 1093, 1103, 53 Cal.Rptr.2d 229, 234].

2. Disability Insurers

In recent years, there has been a proliferation of takeovers and mergers in the disability insurance industry. The resulting mega-insurers have been closing their California claim offices and centralizing all operations at home offices outside of the state. In certain instances, this has led to claims personnel having only a limited knowledge of California statutes, regulations and case law concerning disability insurers' obligations to their policyholders.

As a result, it is more imperative than ever that insureds' attorneys have a solid understanding of California law regarding a disability carrier's duties, including the implied covenant of good faith and fair dealing. That implied covenant includes the duty to: thoroughly investigate the insured's claim, and to "fully inquire into all possible bases that might support the insured's claim";⁶

objectively evaluate the insured's claim;⁷

promptly investigate the insured's claim;⁸

timely respond to the insured's inquiries and otherwise communicate with the insured;⁹

contact and speak with the insured's treating physicians;¹⁰

truthfully represent to the insured what is covered under the policy;¹¹

timely pay benefits due under the policy;¹²

reserve rights only when it has a good faith belief in the existence of the rights asserted;¹³

institute declaratory relief or other litigation against its insured only where it has a reasonable basis for doing so;¹⁴

refrain from construing a disability policy term in a more restrictive manner than the accepted legal definition;¹⁵ and

refrain from imposing additional preconditions to coverage beyond those set forth in the policy.¹⁶

KEY DEFENSES AND HOW TO COUNTER THEM

1. ERISA

If your potential client's policy or health plan was provided by his employer, the insurer will argue that his civil suit is preempted by the Employee Retirement Income Security Act (ERISA). Remedies in connection with an ERISA-preempted insurance policy, healthcare plan or self-insured benefit plan are limited to the benefits owed and, in the court's discretion, reasonable attorney's fees. Thus, most courts hold that no consequential damages, emotional distress damages or punitive damages can be recovered in an ERISA action.¹⁷

Here are a few ways to attempt to circumvent ERISA:

An independent contractor is not an "employee" and is therefore not subject to ERISA preemption,¹⁸ unless he obtains insurance benefits through the same group plan that covers employees of the company.¹⁹

A government employee or the employee of a public agency is exempt from ERISA [29 U.S.C. section 1003(b); 29 U.S.C. section 1002(32)].

Employees of churches or church-operated businesses are exempt from ERISA [29 U.S.C. section 1003(b)].

Sole proprietors, partners, and their spouses are exempt, so long as the business does not provide benefits under the policy to a common-law employee [29 C.F.R. sections 2510.3-3(b) and (c)].²⁰

Some courts have suggested that a plan is not "established or maintained" by an employer [29 U.S.C. section 1002(1)] unless the employer intended to create an ERISA plan.²¹ Other courts have indicated that an employer has "established or maintained" an ERISA plan only if it actively participated in the design and operation of the plan, directly controlled the day-to-day operation of the plan, exercised substantial discretion over the plan, and/or established a separate administrative scheme to manage the plan.²² Still others have found that the "established or maintained" requirement may not be met even if the employer was significantly involved in the administration of the plan.²³ Certain others have indicated that an ERISA plan has not been "established" where the insurer failed to comply with ERISA's reporting and disclosure requirements and failed to mention ERISA in policy documents, brochures and letters.²⁴ And a few others have held that the "is maintained" requirement implies that the plan must be in current operation,²⁵ and thus that ERISA does not apply where the former employer has sold his business and stopped contributing to the plan²⁶ or has gone bankrupt and ceased any involvement in the plan.²⁷

Plans that fall under the Department of Labor's "safe harbor" regulations [29 C.F.R. 2510.3-1(j)] are exempt from ERISA. The regulations generally state that ERISA is inapplicable where (1) the employer does not "endorse" the program;²⁸ (2) employee participation is completely voluntary; (3) premiums are paid entirely by the employee;²⁹ (4) the employer's sole functions are to permit the insurer to publicize the program, collect the premiums through payroll deductions, and remit the premiums to the insurer; and (5) the employer receives no consideration, except reasonable compensation for collecting and remitting the premiums. Significantly, however, some courts have found the "safe harbor" regulations applicable despite employer activities far beyond those permitted by the regulations.³⁰

An insurer sometimes concedes that the insured is a partner or other non-employee and that the disability policy covers only him, but argues that his claims are nevertheless subject to ERISA because his policy is part of an overall company benefit plan that included other policies which did cover employees. This argument has been made - and soundly rejected - in several recent opinions.³¹

Numerous courts have held that ERISA preempts vicarious liability claims that are based on denial of benefits under an ERISA plan.³² But courts are split on whether ERISA preempts vicarious liability claims against a plan administrator based on the quality of care provided by affiliated health care providers (e.g., a claim that

an HMO was negligent in selecting or supervising physicians rendering care to its members and therefore is liable for their malpractice). The leading case on this issue is *Dukes v. U.S. Healthcare* (3rd Cir. 1995) 57 F.3d 350, in which the court determined that an HMO was vicariously liable for the professional negligence of the medical providers it selected under the plan and that such liability was not preempted by ERISA. Other cases holding that malpractice claims against HMOs are not preempted by ERISA are set forth below.³³

In addition to the cases discussed above, there is a recent indication by the United States Supreme Court that it will be receptive to arguments against ERISA preemption. In *UNUM Life Ins. Co. of America v. Ward* (1999) 526 U.S. 358, 119 S.Ct. 1380, 1390, n. 7, the Court noted that the Solicitor General of the United States - on whose brief the Court had based its ruling in *Pilot Life*³⁴ that ERISA is the exclusive remedy for state law causes of action for bad faith - had changed its position on that issue. Although the Court concluded in *Ward* that it "need not address the Solicitor General's current argument" because *Ward* was suing under ERISA (for benefits due) rather than trying to circumvent it, the case at least suggests that the Court may be open to reconsidering its decision in *Pilot Life*.

And the federal district courts concur. In recent months, district court judges in Colorado³⁵ and Oklahoma³⁶ have relied on *Ward* in ruling that ERISA does not preempt a bad faith cause of action by an insured under a group insurance policy. In so holding, those courts distinguished *Pilot Life Ins. Co. v. Dedeaux* (1987) 481 U.S. 41, 107 S.Ct. 1549, wherein the U.S. Supreme Court had held that Mississippi's bad faith law was preempted by ERISA because it imposed liability against both insurance and non-insurance entities (and therefore did not "regulate insurance" within the meaning of ERISA's "savings clause" [29 USC § 1144(B)(2)(A)] so as to avoid preemption). Conversely, Colorado and Oklahoma limit the cause of action to the insurance industry³⁷ - and so does California.

More specifically, the California Supreme Court has repeatedly held that claims for tortious breach of the implied covenant of good faith and fair dealing (i.e., bad faith) can only be brought in cases involving insurance contracts. For example, the Court held in *Foley v. Interactive Data Corp.* (1988) 47 Cal.3d 654, 684, 254 Cal.Rptr. 211, 228 that it is only "in the context of insurance contracts where . . . breach of the implied covenant will provide the basis for an action in tort (emphasis added). And just last year, the Court reiterated that "compensation for [breach of the implied covenant] has almost always been limited to contract rather than tort remedies" and that "at present, this court recognizes only one exception to that general rule: tort remedies are available for a breach of the covenant in cases involving insurance policies [*Cates Construction Inc. v. Talbot Partners* (1999) 21 Cal.4th 28, 43, 86 Cal.Rptr.2d 855].

Thus, unlike the Mississippi law construed in *Pilot Life* (which allowed tortious bad faith claims in a variety of contexts and therefore did not "regulate insurance"), California's bad faith tort is only available in the insurance arena. For that reason, California's bad faith law should be found to "regulate insurance" and therefore be "saved" from ERISA preemption.

And the same should be true for California's new HMO liability statute [Civil Code section 3428, discussed above]. If the California Legislature has its way, ERISA will not bar employees from suing their HMOs under the new law or limit the damages they can recover in such a suit.

More specifically, the California Legislature has declared that, at least for purposes of statutory liability under Civil Code § 3428, HMOs "are engaged in the business of insurance . . . as that term is defined for purposes of the McCarron-Ferguson Act" [Statutory notes to Civil Code § 3428 (emphasis added)]. This is critical for purposes of ERISA, since ERISA preempts state laws related to employee benefit plans except those laws that "regulate insurance" [29 USC § 1144(B)(2)(A)] - and a state law "regulates insurance" if it (1) is specifically directed toward the insurance industry and (2) fits within the "business of insurance" as that phrase is used in the McCarron-Ferguson Act [15 USC §1011 et seq.; see also *UNUM Life Insurance Co. of America v. Ward* (1999) 526 U.S. 358, 119 S.Ct. 1380, discussed above].

Thus, the California Legislature's clear goal is to protect the new HMO liability statute from ERISA exemption. And to remove any doubt, the Legislature has declared that its intention is "to ensure that adequate state law remedies exist for all persons who are subject to the wrongful acts of those entities that contract to provide insurance for the life, health and disability of California citizens" [Statutory notes to Civil Code § 3428 (emphasis added)]. Nevertheless, it remains to be seen whether such legislative recitals will be enough to avoid ERISA preemption.

2. Arbitration

If your potential client's policy or health plan has an arbitration clause, there are numerous arguments you can make to try to circumvent arbitration and get his case to court. For example:

The insured did not knowingly agree to arbitration³⁸

The insured was fraudulently induced to enter the arbitration agreement³⁹

The insurer waived its right to arbitration by (1) delaying its pursuit of arbitration (either by delaying in bringing the arbitration provision to the insured's attention after it learned that the insured disagreed with the insurer's coverage determination⁴⁰ or by delaying in filing a petition to compel arbitration after the insured had filed a civil action⁴¹) and/or (2) engaging in litigation conduct (propounding demurrers, filing motions, attending court hearings, propounding discovery, etc.) inconsistent with an intent to arbitrate⁴²

he arbitration clause is unconscionable because it (1) bars recovery of tort or punitive damages in arbitration or otherwise restricts remedies available in arbitration,⁴³ (2) calls for selection of an arbitrator affiliated with one of the parties to the contract⁴⁴ or (3) is hidden in a non-negotiable pre-printed consumer loan contract and requires that arbitration take place in another state⁴⁵

The claims alleged by the plaintiff are beyond the scope of the arbitration provision⁴⁶

Arbitration is too expensive (steep filing fees, arbitrators' costs, etc.)⁴⁷

3. Medicare

A growing number of senior citizens who qualify for Medicare benefits are opting for coverage under HMO senior care plans. If you decide to represent a senior who has been denied benefits by his HMO or other insurer, you likely will be faced with an argument that tort claims arising from the wrongful refusal to provide benefits under a senior care plan are preempted by the Medicare administrative review statutes.

Fortunately, however, the U.S. Department of Health and Human Services -- the federal agency that administers Medicare -- has recently confirmed, in a published analysis, that "tort claims or contract claims under State law are not preempted" by Medicare [63 Fed. Reg. 34968, 35013]. In addition, numerous courts have flatly rejected Medicare preemption of bad faith suits and other tort actions. Helpful cases on this issue include *Ardary v. Aetna Health Plans* (9th Cir. 1996) 98 F.3d 496, *Solorzano v. Superior Court (FHP, Inc.)* (1992) 10 Cal.App.4th 1135, 13 Cal.Rptr.2d, *Wartenberg v. Aetna U.S. Healthcare, Inc.* (E.D. N.Y. 1998) 2 F.Supp.2d 273, *Albright v. Kaiser Permanente Med. Grp.* (N.D. Cal. 1999) 1999 WL 605828 and *Plocica v. NYLCARE of Texas, Inc.* (N.D. Tex. 1999) 43 F.Supp.2d 658.48

Finally, please note that the California Supreme Court has accepted the Medicare preemption issue for review in *McCall v. Pacificare of Cal., Inc.*, Supreme Court Case No. S082236.

4. Comparative Bad Faith

In *Commercial Union Assurance Companies v. Safeway Stores* (1980) 26 Cal.3d 912, 164 Cal.Rptr. 709, the California Supreme Court determined that 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". 26 Cal.3d at 918. Based thereon, an insurer sued for bad faith sometimes tries to reduce its exposure by arguing that its insured withheld information requested by the insurer, delayed in responding to the insurer's inquiries, or otherwise breached the insured's duty of good faith.

But this litigation tactic was recently rejected by the California Supreme Court. In *Kransco v. American Empire Surplus Lines* (2000) 23 Cal.4th 390, 97 Cal.Rptr.2d 151, the Court held that an insurer cannot assert the "comparative bad faith" of its insured as an affirmative defense in a bad faith action brought by the insured.

CONCLUSION

Obviously, it is not easy to pick the right bad faith case, develop the appropriate theories of liability, and circumvent the myriad of defenses asserted by the insurer. We hope that this syllabus and the presentation that accompanies it will prove helpful in your efforts to do so.

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1. The care need not have been recommended or furnished by one of the HMO's in-plan providers. It may have been recommended by any health care provider, as long as the recommendation was within the scope of the provider's practice [Civil Code § 3428(b)(2)].
 2. "Substantial harm" means loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, severe and chronic physical pain, or significant financial loss [Civil Code § 3428(b)(1)].
 3. See also *Washington Physicians Service Assoc. v. Gregoire* (9th Cir. 1998) 147 F.3d 1039, 1045-1046, which found that that because "[i]n the end, HMOs function the same way as a traditional health insurer" and "are engaged in the business of health insurance", any nominal variance between HMOs and traditional insurers is "a distinction without a difference".
 4. The *Wilson* court also held that an HMO enrollee can sue the HMO's physician provider group for interference with the enrollee's contractual relationship with the HMO. *Id.* at 672-674.
 5. In *Pegram v. Herdrich* (June 12, 2000) 120 S.Ct. 2143, the United States Supreme Court held that HMO enrollees cannot bring ERISA claims for breach of fiduciary duty against their HMOs in federal court, at least where the claims are nothing more than "wholesale attacks on existing HMOs solely because of their structure, untethered to claims of concrete harm". *Id.* at 2153. However, the Court left the door open to state and other federal suits against HMOs (and perhaps even ERISA claims that allege specific harm arising from the breach of fiduciary duty).
 6. *Egan v. Mutual of Omaha Ins. Co.* (1979) 24 Cal.3d 809, 819, 169 Cal.Rptr. 691, 696; *Mariscal v. Old Republic Ins. Co.* (1996) 42 Cal.4th 1617, 1623, 50 Cal.Rptr.2d 224.
 7. *Hughes v. Blue Cross of Northern California* (1989) 215 Cal.App.3d 832, 845-846, 263 Cal.Rptr. 850, *Blake v. Aetna Life Insurance Co.* (1979) 99 Cal.App.3d 901, 924, 160 Cal.Rptr. 528.
 8. *Murray v. State Farm Fire and Cas. Co.* (1990) 219 Cal.App.3d 58, 65, 268 Cal.Rptr. 33, 37.
 9. *Delgado v. Heritage Life Insurance Co.* (1984) 157 Cal.App.3d 262, 278, 203 Cal.Rptr. 672, 681.
 10. *Egan*, *supra*, 24 Cal.3d 809, 819, 169 Cal.Rptr. 691; *Mariscal*, *supra*, 42 Cal.4th 1617, 1624-1625, 50

Cal.Rptr.2d 224.

11. *Delos v. Farmers Insurance Group* (1979) 93 Cal.App.3d 642, 664, 155 Cal.Rptr. 843, 857.

12. *McCormick v. Sentinel Life Ins. Co.* (1984), 153 Cal.App.3d 1030, 1035, 1050-1051, 200 Cal.Rptr. 732, 733, 744.

13. *Fletcher v. Western National Life Ins. Co.* (1970) 10 Cal.App.3d 376, 395, 89 Cal.Rptr. 78, 89; *Sprague v. Equifax, Inc.* (1985) 166 Cal.App.3d 1012, 1032, 213 Cal.Rptr. 69, 82.

14. *Kelly v. Farmers Ins. Exchange* (1987) 194 Cal.App.3d 1, 239 Cal.Rptr. 259; *Dalrymple v. USAA* (1995) 40 Cal.App.4th 497, 513-515, 46 Cal.Rptr.2d 845, 853-854.

15. *Moore v. American United Life Ins. Co.* (1984) 150 Cal.App.3d 610, 626, 197 Cal.Rptr. 878, 887-888.

16. *Mission Ins. Group v. Merco Construction Engineers* (1983) 147 Cal.App.3d 1059, 1066-1068, 195 Cal.Rptr. 791.

17. *Mass. Mut. Life Ins. Co. v. Russell* (1985) 473 U.S. 134, 142-144, 105 S.Ct. 3085, 3090; *Mertens v. Hewitt Assoc.* (1983) 508 U.S. 248, 113 S.Ct. 2063, 2069.

18. *Nationwide Mut. Ins. Co. v. Darden*, 503 U.S. 319, 327, 112 S.Ct. 1344, 1350 (1992); *Barnhart v. New York Life* (9th Cir. 1998) 141 F.3d 1310.

19. *Harper v. American Chambers Life Ins. Co.* (9th Cir. 1990) 89 F.2d 1432, 1434.

20. See also *Robertson v. Alexander Grant & Co.* (5th Cir. 1986) 798 F.2d 868; *Meredith v. Time Insurance Co.* (5th Cir. 1993) 980 F.2d 352; *Fugarino v. Hartford Life & Acc. Ins. Co.* (6th Cir. 1992) 969 F.2d 178; *Slamen v. Paul Revere Life Insurance Co.* (11th Cir. 1999) 166 F.3d 1102, 1104.

21. See *Kanne v. Connecticut General Life Ins. Co.* (9th Cir. 1988) 867 F.2d 489, 493; *Stanton v. Paul Revere Life Ins. Co.* (S.D. Cal. 1999) 37 F.Supp.2d 1159; *Hansen v. Continental Ins. Co.* (5th Cir. 1991) 940 F.2d 971, 978.

22. See *Hansen*, 940 F.2d at 978; *Johnson v. Watts Regulator Co.* (1st Cir. 1995) 63 F.3d 1129, 1134; *Elco Mechanical Contractors, Inc. v. Builders Supply Assoc. of West Virginia* (S.D. W. Va. 1993) 832 F.Supp. 1054, 1057-1058; *Taggart Corp. v. Life and Health Benefits Administration, Inc.* (5th Cir. 1980) 617 F.2d 1208, 1210; and *Sindelar v. Canada Transport, Inc.* (Neb. 1994) 520 N.W.2d 203, 207.

23. See *Zavora v. Paul Revere Life Ins. Co.* (9th Cir. 1998) 145 F.3d 1118, 1121; *du Mortier v. Massachusetts General Life Ins. Co.*, *supra* (C.D. Cal. 1992) 805 F.Supp. 816, 821; *Garrett v. Delta Air Lines, Inc.* (N.D. Ind. 1978) 1978 U.S. Dist. LEXIS 16460 and *Johnson*, *supra*, 63 F.3d 1129.

24. See *du Mortier* and *Johnson*, *supra*.

25. See *Stanton*, *supra*, (S.D. Cal. 1999) 37 F.Supp.2d 1159.

26. *Loudermilch v. The New England Mutual Life Ins. Co.* (S.D. Ala. 1996) 942 F.Supp. 1434.

27. *Mizrahi v. Provident Life and Accident Ins. Co.* (S.D. Fla. 1998) 994 F.Supp. 1452.

28. "Endorsement of a program requires more than merely recommending it". Johnson v. Watts Regulator Co. (1st Cir. 1995) 63 F.3d 1129, 1136.

29. The mere fact that the employer gave employees the option of using a portion of their pre-tax salary to purchase plan benefits does not mean that it contributed to the payment of plan premiums. See Hrabe v. Paul Revere Life Insurance Company (M.D. Ala. 1996) 951 F.Supp. 997, 1001.

30. Garrett v. Delta Air Lines, Inc. (N.D. Ind. 1978) 1978 U.S. Dist. LEXIS 16460 and Johnson v. Watts Regulator Co. (1st Cir. 1995) 63 F.3d 1129.

31. Slamen v. Paul Revere Life Insurance Co. (11th Cir. 1999) 166 F.3d 1102 ["Non-ERISA benefits do not fall within ERISA's reach merely because they are included in a multibenefit plan along with ERISA benefits"]; Rand v. The Equitable Life Assur. Society of the U.S. (E.D.N.Y. 1999) 49 F.Supp.2d 111 ["The plaintiff's disability insurance policies, which are not covered by ERISA, are not converted into an ERISA plan merely because the plaintiff's employees received unrelated health insurance"]; In re Watson (9th Cir. 1998) 161 F.3d 593, 596, n. 4 ["Even if the plans were created simultaneously or shared other common characteristics, they are independent plans under ERISA"]; see also Agrawal v. Paul Revere Life Ins. Co. (2000) 205 F.3d 297; Robertson v. Alexander Grant & Co. (5th Cir. 1986) 798 F.2d 868, Fugarino v. Hartford Life & Acc. Ins. Co. (6th Cir. 1992) 969 F.2d 178, and Stanton v. Paul Revere Life Ins. Co. (S.D. Cal. 1999) 37 F.Supp.2d 1159.

32. For example, in Jass v. Prudential Health Care Plan, Inc. (7th Cir. 1996) 88 F.3d 1482, 1489, the Court held that ERISA preempted a suit alleging that an ERISA plan administrator's employees or adjusters failed to properly investigate a claim and wrongfully denied benefits due.

33. Chaghervand v. Carefirst, 909 F.Supp. 304 (D. MD 1995); Dearmas v. Hechavarria, 865 F.Supp. (S.D. FL 1994); Dykema v. King, 959 F.Supp. 736 (D. S.C. 1997); Edelen v. Osterman (D.C. 1996) 943 F.Supp. 75; Elsesser v. Hospital of the Philadelphia College, etc., et al. (E.D. Pa 1992) 802 F.Supp 1286; Haas v. Group Health Plan, Inc. (S.D. IL 1994) 875 F.Supp. 544; Independence HMO, Inc. v. Smith (E.D. Pa 1990) 733 F.Supp. 983; Jackson v. Roseman (D. Md 1995) 878 F.Supp. 820; Kearney v. U.S. Healthcare (E.D. Pa 1994) 859 F.Supp. 182; Ouellette v. Christ Hospital (S.D. Oh 1996) 942 F.Supp. 1160; Pacificare of Oklahoma, Inc. v. Burrage (10th Cir. 1995) 59 F.3d 151; Prihoda v. Shpritz (D. Md 1996) 914 F.Supp. 113; Rice v. Panchal (7th Cir. 1995) 65 F.3d 637; Roessert v. Health Net (N.D. Ca 1996) 929 F.Supp. 343; Sanitoro v. Evans (E.D.N.C. 1996) 935 F.Supp. 733; and Smith v. HMO Great Lakes (N.D. IL 1994) 852 F.Supp. 669.

34. Pilot Life Ins. Co. v. Dedeaux (1987) 481 U.S. 41, 107 S.Ct. 1549.

35. Hall v. UNUM Life Ins. Co. of America, U.S. District Court for the District of Colorado, Case No. 97-M-1828, November 1, 1999 Order by Chief Judge Richard S. Matsch Granting Motion For Leave To File Amended And Supplemental Complaint Adding Third Claim For Relief. Note that although the unpublished order did not expressly reference the Supreme Court's decision in Ward, the order was issued in response to a motion (for leave to file an amended and supplemental complaint) that had been based solely on Ward.

36. Lewis v. Aetna U.S. Healthcare, Inc. (N.D. Ok. 1999), No. 99-CV-104-H(M).

37. For example, in Oklahoma the tort of bad faith is "specific to the insurance industry" [Lewis, 78 F.Supp.2d at 1215], "applie[s] exclusively to contracts between insurance companies and their insureds" [Id. at 1212] and "has never been extended beyond the insurance area" [Id. at 1208].

38. United Steelworkers v. Warrior & Gulf Navigation Co. (1960) 363 U.S. 574, 582; Badie v. Bank of America (1998) 67 Cal.App.4th 779, 79 Cal.Rptr.2d 273.

39. *Engalla v. Permanente Medical Group, Inc.* (1997) 15 Cal.4th 951, 64 Cal.Rptr.2d 843.
40. *Sarchet v. Blue Shield of Calif.* (1987) 43 Cal.3d 1, 14-15, 233 Cal.Rptr. 76, 85 .
41. *Sobremonte v. Superior Court* (1998) 61 Cal.App.4th 980, 72 Cal.Rptr.2d 43 (10-month delay); *Davis v. Continental Airlines* (1997) 59 Cal.App.4th 205, 69 Cal.Rptr.2d 1379 (6-month delay).
42. *Davis, supra*; *Sobremonte, supra*; *Hayworth v. City of Oakland* (1982) 129 Cal.App.3d 723, 729-730, 181 Cal.Rptr. 214, 218; *Berman v. Health Net* (2000) 80 Cal.App.4th 1359, 1363, 96 Cal.Rptr.2d 295, 298.
43. *Stirlen v. Supercuts, Inc.* (1997) 51 Cal.App.4th 1519, 60 Cal.Rptr.2d 138; *Kinney v. United Healthcare Services* (1999) 70 Cal.App.4th 1322, 83 Cal.Rptr.2d 348; *Graham Oil Co. v. Arco Products Co.*, *supra* (9th Cir. 1994) 43 F.3d 1244; *Paladino v. Avnet Computer Technologies, Inc.* (11th Cir. 1998) 134 F.3d 1054.
44. *Graham v. Scissor-Tail, Inc.* (1981) 28 Cal.3d 807, 171 Cal.Rptr. 604.
45. *Patterson v. ITT Consumer Financial Corp.* (1993) 14 Cal.App.4th 1659, 18 Cal.Rptr.2d 563.
46. *AT&T Technologies v. Communication Workers of America* (1986) 475 U.S. 643, 648, 106 S.Ct. 1415, 1418; *Ericksen, Arbuthnot, McCarthy, Kearney & Walsh, Inc. v. 100 Oak Street* (1983) 35 Cal.3d. 312, 323, 197 Cal.Rptr. 581, 587; *Mansdorf v. California Physicians' Service, Inc.* (1978) 87 Cal.App.3d 412, 151 Cal.Rptr. 388; *Cobler v. Stanley, Barber, Southard, Brown & Assoc.* (1990) 217 Cal.App.3d 518, 265 Cal.Rptr. 868.
47. *Randolph v. Green Tree Financial Corp.* (11th Cir. 1999) 178 F.3d 1149.
48. Other favorable cases concerning Medicare preemption include *Talbot v. Lucy Corr Nursing Home* (4th Cir. 1997) 118 F.3d 215, *Berman v. Abington Radiology Assoc., Inc.* (E.D. Pa. 1997) 1997 WL 534804, *Zamora-Quezada v Health Texas* (W.D. Tex. 1998) 34 F.Supp.2d 433, *Winkler v. Interim Services, Inc.* (M.D. Tenn. 1999) 36 F.Supp.2d 1026, *Kelly v. Advantage Health, Inc.* (E.D. La. 1999) 1999 WL 294796, and *Caputo v. U.S. Health Care Systems of Pa.* (E.D. Pa. 1998) 1998 WL 808611.